



Waterfront  
Montessori  
Children's  
Centre

# Medical Permission Form

Child's Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Medication: \_\_\_\_\_

Amount/Dosage: \_\_\_\_\_

Time Given: \_\_\_\_\_

Dates – from: \_\_\_\_\_

Month / Day / Year

to: \_\_\_\_\_

Month / Day / Year

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date