THE BRITISH INTERNATIONAL SCHOOL
ABU DHABI
A NORD ANGLIA EDUCATION SCHOOL

Consent for Prescription Medication during the School Day or Related School Activities **(to be completed, signed and stamped by Licensed Physician)**	
Student Name:	Health condition for which the medication is prescribed:
Date of Birth (Day/Month/Year):	Name of medication:
Dose:	This medication should be continued until:
Route for administering the medication: ☐ By Mouth ☐ Injection ☐ Other: (please specify) …… ☐ Inhalation ☐ Topical	
What time does medication need to be given at school: ……AM ……PM	
Any precautions that school personnel need to know?	Any contraindications that school personnel need to know?
What are possible reactions/side effects?	What should be done in the event of reaction/side effect?
Check appropriate box below: ☐ I authorize this student to **self-administer** the above medication ☐ The above medication can only be administered by a DOH Licensed School Nurse	
Name and phone number of Healthcare Provider	Signature of the treating physician prescribing the medication

Parent/Guardian to complete

I understand it is my responsibility to send the medication to school in the original pharmacy container labelled with my child's name, treating physician's instructions/care plan and any other documentation to assist in the safe administration of the specified medications.

Parent/Guardian Full Name: _____ Parent/Guardian Signature: _____ Date: _____