Authorization for Prescription Medication

Name of Student: _____

Diagnosis: _____

Medication & Dosage Prescribed: _____

Instructions for Administering Prescription Medicine

(Medicine must be provided in a pharmacy container indicating the Student's Name as well as complete instructions for dispensing. Prescribing labels that state "Take as Directed" will NOT be accepted.)

_____

_____

_____

_____

Side Effects of Prescription Medicine

_____

_____

_____

Physician's Name: _____ **Phone:** _____

Parental Permission (to be completed by Parent/ Legal Guardian):

I grant the Health Care Manager or his/her designated chaperone permission of our Student's School, _____, to assist in the administration of each prescribed medication to be provided.

I hereby release and hold Nord Anglia Education and its affiliated companies and schools and their respective officers, employees, agents and representatives harmless from any liability for administering these prescription medications.

Parent/ Guardian Name: _____ Phone Number: _____

_____ _____

Signature of Parent/Legal Guardian (please type name) Date of Signature