



## 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