St. Joseph's School
Abu Dhabi

PARENTAL CONSENT TO ADMINSTER PRESCRIBED MEDICATION

SECTION 1 (to be filled out and signed by the HAAD Licensed Physician)

Student Name:____ **Reg. No.**_________
First *Middle* *Last*

Class:________ **Div:**____________ **Date of Birth**(dd/mm/yyyy)______________________

Reason for medication (Diagonsis):____

Name of Medication:____

Dosage to be taken at school:____

Time medication should ne administered:____

Duration of the Treatment:________________Route of administration:_________________________

Check the appropriate box below:

◯ I authorize this student to self-administer the above medication.

◯ The above medication can only be administered by a HAAD Licensed School Nurse.

Signature of the treating physician prescribing the medication:____________________________

Phone Number:__________________________ **Date:**___________________________________

Date:___________________________

SECTION 2 (to be completed and signed by the parents for guardian)

1. I give consent for St. Joseph's School to administer the following prescription medication that I have provided for St. Joseph's School to my child, according to the direction given below.
2. I agree to release and hold harmless the school and any of their staff members from any liability against them for assisting this student with the directions given above.
3. I understand it is my responsibility to send the medication to school in the original pharmacy container labeled with the details outline in the Section 1 of this form.

Parent's/Guardian Name:________________________ **Signature:**_____________

Phone No./Mobile No:__________________________________

Note: To be filled for those students who are taking regular medication/emergency medications.