The Anglo-American School of Moscow

HEALTH OFFICE
+ 7 495 231 44 62
health.office@aas.ru
https://www.aas.ru/student-life/health-office

MEDICATION WAIVER OF RESPONSIBILITY

Name of the student:____

D.O.B:_______________________________________Grade:______________________

Medication (name, dose, route of administration): ________________________________

____

____

Time of administration:____

Medication should be administered

From _______/__________/20_______ To__________/___________/20______

Instructions: ____

I ____, hereby give permission to the Health Office Staff at AAS Moscow to administer the medication listed above, prescribed by our Doctor for my daughter/son.

I fully understand the use and the purpose of the medication, the side effects of the medication to be administered by the AAS Health Office staff for my daughter/son.

I understand that I must supply the school with the prescribed medication in the original container properly labeled and with a copy of the original order from the doctor and that the first dose of the medication has already been administered.

____

Signature of the parent Date

____

Health Office Staff Date