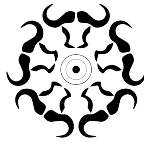

AISM
American International School of Mozambique

MEDICATION AUTHORIZATION

Student Surname ____

First Name ____

Date of Birth ____

Grade ____

PARENTAL CONSENT

I request that the Nurse administer this medication to my child, according to the directions below:

Date ____

Signature _______________________________________

Name of medication	
Dosage /amount to be given	
Time to be administered	
Duration (week, month, indefinite etc.)	
Reason / medical condition	
Possible side effects	