Seoul International School Medication Authorization

Name of Student:_____

Birth of Date: _____ **Division:** □ **ES** □ **MS** □ **HS** **Grade:** _____

To be completed by Physician:

Medical Condition(s):

_____

Medication(s):

_____

Dose: _____Time to be give: _____ Route: _____

Possible side effects:

_____

Start Date: _____ Stop Date:_____ To be refrigerated: □ Yes / □ No

PHYSICIAN SIGNATURE: _____Date: _____

Clinic Name: _____Phone: _____

To be completed by Parent:

I hereby give my permission for_____to receive, from the School Nurse and/or other trained school personnel, the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. I give permission for the school nurse and health care providers at the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed and my child's response to the medication.

_____ _____

Signature of Parent/Guardian Date

NOTE: The prescription medication must be brought to school in the original container, properly labeled by pharmacy or physician, stating the name of the student, the medication, the dosage and current date. The medication will remain at school for the duration of the prescription.