PERMISSION TO GIVE MEDICATION FORM

UWC SOUTH EAST ASIA

Please complete the form in full and to return it with medicines to the relevant clinic/personnel.

Please note: The College is unable to accept medication unless it is in the original pharmacy-administered packaging, with the student's name, current expiry date visible, and all instructions in English *(i.e., Prescription Only Medication (POM) must have a written prescription and Over-The-Counter (OTC) medication must have the manufacturer's administration instructions)*.
The College is unable to accept or administer alternative medicine such as homeopathic or Ayurvedic therapies, vitamins or supplements.

Name of student (in block letters): _____

Class/mentor/tutor group: _____ Date of birth (DD/MM/YYYY): _____ Weight: _____

Drug allergies: _____

Diagnosis: _____

☐ **I consent for the Clinical Nurse/first-aider to administer the following medication to my child as directed and am aware that these details may be disclosed to UWCSEA staff.**

Name of medication	Quantity dose supplied	Dose to take	Route (e.g., ear, eye, nasal, oral, or topical)	Time to be given/frequency	Expiry date	Any other instructions (e.g., start/end date; when necessary only; complete the course; before/after food; may cause drowsiness)

☐ **course completed in school** ☐ **medication returned to parents** ☐ **parent consents to child taking any surplus medication home in bag**

Name of parent/guardian (in block letters): _____ Signature of parent/guardian: _____

Parent/guardian email address : _____ Contact number: _____ Date: _____

Name of Clinical Nurse/first-aider: _____ Signature of Clinical Nurse/first-aider: _____ Date: _____

If you have any further queries, please contact our Clinical Nurse at collegeclinicdover@uwcsea@edu.sg (Dover Campus) or collegecliniceast@uwcsea.edu.sg (East Campus).

last updated: May2019 | 214MISC-1819

INDIVIDUAL MEDICAL RECORD

UWC SOUTH EAST ASIA

Name: _____ **Mentor group:** _____ **Date of birth:** _____	**Prescribed by**	
	Drug allergies	
	Diagnosis	

Drug name/Dose/Freq./Qty	**Date**	**Time/Initial**			
_____ Take ____ tab./cap./sac./mls _____ times daily ( ) Morning / Noon / Evening / Bedtime ☐ Before meal ☐ After meal ☐ May cause drowsiness ☐ When necessary ☐ Complete this course of medication Route:					
Drug name/Dose/Freq./Qty	**Date**	**Time/Initial**			
_____ Take ____ tab./cap./sac./mls _____ times daily ( ) Morning / Noon / Evening / Bedtime ☐ Before meal ☐ After meal ☐ May cause drowsiness ☐ When necessary ☐ Complete this course of medication Route:					
Drug name/Dose/Freq./Qty	**Date**	**Time/Initial**			
_____ Take ____ tab./cap./sac./mls _____ times daily ( ) Morning / Noon / Evening / Bedtime ☐ Before meal ☐ After meal ☐ May cause drowsiness ☐ When necessary ☐ Complete this course of medication Route:					