ISB Permission for Medication Form (v2.2)

Name of Student & Grade: _____ Date of Birth: _____

Diagnosis: _____

Regular Medication

The following medication(s) should be given at the time stated

Name of Medication: **Dosage:** **Time:** **Route:** **Duration:** **Special Instructions:**	**Name of Medication:** **Dosage:** **Time:** **Route:** **Duration:** **Special Instructions:**

As-required/Rescue Medication (ie Paracetamol, Ibuprofen, Iberogast drops, Cetirizine)

Name of Medication: **Dosage:** **Route:** **For the following symptoms:**	**Name of Medication:** **Dosage:** **Route:** **For the following symptoms:**

Prescription-free "medication"

My child may receive the following (please tick as appropriate)

- Band aid ☐
- Wound spray ☐
- Bepanthene wound cream ☐
- Betaisodona wound cream ☐
- Fenistil Gel ☐

: _____

Authorisation of the Parent / Legal guardian:

I give permission for the Health Coordinator, Mrs Brinkmann-Mclean and (staff name) _____

to administer the above medication and I confirm that my child/ the student named herewith has received the above medication previously, without adverse side effects.

Name of Parent / Guardian_____

Signature: _____ Date: _____

Date of implementation: August 2021
Policy review date: August 2023

Record of Administration of Medicines

Date:	Time:	Name/Dosage of Medicine	Signature