



**International School Bangkok
Physician/Parental Consent for the administration of long term
prescription medication at school**

This part must be completed by a physician

Student Family Name: _____ Given Name: _____

Date of Birth (dd/mm/yyyy): _____ Grader: _____

Drug allergies: _____ Condition being treated: _____

The above named student requires the following prescription medication administered whilst at school:

Name of Medication	Dose (mg)	Time/times for administration	Other instructions e.g. give before/after food, dose will be gradually increased/reduced

Note: all medication must be supplied in its original packaging in English or Thai with expiry date clearly visible and prescription label attached.

I have discussed with the parents and the student possible side effects and precautions that must be taken with this medication.

Signature of Medical Practitioner: _____ Date (dd/mm/yy): _____

Name of Medical Practitioner: _____

Qualifications: _____ Official Stamp: _____

Parental consent

I/We undertake that I/we have given ISB authority to administer this medication on my/our behalf and accept full responsibility for the same in the event that my child has any adverse reaction to this medication, provided that the medication was administered in accordance with the physician's instructions.

I/We agree to inform ISB of any prescription changes in writing, to replenish supplies when necessary, and to ensure they meet the medication guidelines above.

Signed: _____

Signed: _____

Name: _____

Name: _____

Date (dd/mm/yyyy): _____

Date (dd/mm/yyyy): _____

Receiving nurse sign and date: _____ Amount received: _____ Expiry date _____