SINGAPORE AMERICAN SCHOOL

Authorization to Administer Medications

STUDENT INFORMATION

Name _____ Grade _____ Teacher _____

Last Name *First Name* *Middle Name*

We encourage medications (both prescription and over-the-counter) to be administered at home. For those students who need medication during school hours, SAS requires this form be completed by a parent or physician before any medications are administered. Both prescription and OTC medication must be supplied in the original manufacturer's packaging. Additionally, prescription medication must display the pharmacy/clinic/physician label.

I request that my child _____ receive the following medication(s):

Last Name *First Name* *Middle Name*

MEDICATION	DIAGNOSIS	DOSAGE	ROUTE	TIME/FREQUENCY	LENGTH OF TREATMENT	EXPIRY DATE

Parent/Guardian Name _____

Last Name *First Name*

_____

Parent/Guardian Signature *MM/DD/YYYY*