GRADED
THE AMERICAN SCHOOL OF SÃO PAULO

Dear Parent or Guardian

This form will also be used for all external trips and events throughout the 2025-2026 school year. To comply with Brazilian law, nurses need a medical prescription in order to medicate students. Please ask your physician to fill out this form with the medications, so that they may be administered to your child, if necessary. **Filled out by a DOCTOR with a Brazilian License (CRM) – stamp and sign needed/ *Preenchimento por um Médico com CRM ativo – necessário carimbo*). Please ask your doctor to print, stamp, sign the prescription, and send it to us by mail OR directly send us the digital prescription.**

STUDENT INFORMATION /*INFORMAÇÕES DO ALUNO* ***Emergency Hospital:*** _____

Name/ *Nome*: _____ DOB/ *Data Nascimento*: ____ /____ /____

Parent 1/ *Responsável 1*: _____ Phone number/ *Telefone:* _____

Parent 2/ *Responsável 2*: _____ Phone number/ *Telefone:* _____

HEALTH CONDITIONS / *PROBLEMAS DE SAÚDE*
(Preenchimento pelo pai/responsável/ Filled out by parent/guardian)
Asthma or Bronchitis - Allergic reaction - Diabetes - ADHD - Anxiety

---

DOCTOR'S PRESCRIPTION / PRESCRIÇÃO MÉDICA
MEDICATION AVAILABLE AT SCHOOL: Pain: Dipirona, Ibuprofen, Tylenol / Allergy: Loratadina, Dicloridrato de Hidroxizina 2mg/ml and Cloridrato de Fexofenadina / Nausea: Dramin B6 and Cloridrato de Ondansetrona 4mg / Cramps: Butilbrometo de Escopolamina and Ácido Mefenâmico 500 mg - Please select Yes (Y) or Not (N)

Medication for Pain	Medication for Allergy	Medication Gases relief	Medication for Cramps	Medication for Nausea
Dipirona - ☐**Y** ☐**N**	Loratadina - ☐**Y** ☐**N**	Luftal - ☐**Y** ☐**N**	Butilbrometo Escopolamina- ☐**Y** ☐**N**	Dramin B6 - ☐**Y** ☐**N**
Ibuprofen - ☐**Y** ☐**N**	Dicloridrato Hidroxizina 2mg/ml - ☐**Y** ☐**N**		Ácido Mefenâmico 500mg - ☐**Y** ☐**N**	Cloridrato Ondansetrona 4mg - ☐**Y** ☐**N**
Tylenol - ☐**Y** ☐**N**	Cloridrato de Fexofenadina - ☐**Y** ☐**N**		Buscopan Composto - ☐**Y** ☐**N**	

Other medication- please provide to the school Doctor's prescription stating that your Child could take it at school and all additional medication necessary. *Outros medicamentos - forneça à escola a receita médica do médico afirmando que seu filho pode tomá-la na escola, além de todos os medicamentos adicionais necessários.*

_____

_____

_____ _____

Date **Doctor's Signature and Stamp with Name and *CRM Number***