SHA TIN JUNIOR SCHOOL

Authorisation Form for Ongoing/ Daily Prescribed Medication

Student's Name ____

Last First Middle initial

Date of Birth ________________________ Year & Section __________________________

It is necessary for the following medication to be administered regularly during school hours in the form and dosage specified below, in order to maintain this child's physical health and provide maximum school performance.

Name of medication ____

Time & Dosage to be given ____

Possible side effects/ Adverse reactions ____

I hereby grant permission for the School Health Professional or deputy, to administer the above medication to my child and to communicate with my child's physician when it's necessary with regard to this medication. I agree that the medication has to be taken during break time so as not to interfere with lessons.

Parent/ Guardian's Signature ____________________ Date _________________

<u>TO BE COMPLETED BY THE PHYSICIAN</u>

Name of patient ____

Diagnosis for which medication is prescribed _______________________________________

Name of medication ____

Dosage (Be specific, i.e., milligrams, etc) ____

Precautions, reactions or side effects ____

_____________________ _____________________ _________________

Printed Name Signature Date

Contact No. _________________________