ST.PAUL AMERICAN SCHOOL HANOI

MEDICATION REQUEST

Name of students: _____ Grade: _____

It is necessary for him/her to have the following medication during school hours:

• Medication: ……

• Dosage: ……..

• Time to Be Administered: ……

• Diagnosis: ……...

• Any medication allergies? …… If yes, please list: ……

……

• Adverse reactions that may occur:

……..

Medication will be administered in school:

Starting on (date)……: and Terminated on (date)……

I hereby give permission for my child to receive medication at school as prescribed above by my child's physician.

I also give permission for the release and exchange of information between the school nurse concerning my child's health and treatment.

Date: _____ Parent/Guardian Signature: _____