ISE International School Eindhoven	**Permission for School Administration of Prescription Medication**	For school use only: o Routine o PRN (As needed) Start Date: _____

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school should be accompanied by this form, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. If this medication is to be given due to a medical condition also listed on the Medical Alert form please ensure the Medical Alert form is filled out and/or updated accordingly. A permission form is required to be completed for each medication to be administered at school.

Child's Name
Date of Birth

Teacher/Year Tutor Name
Group/Class

Medication:		Dosage:
Purpose of Medication:		Route:
Time medication to be given:	Frequency: (e.g., daily)	Note special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ Until end of current school year ☐ _ weeks ☐ _ days		Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies, include on Medical Alert form) Is this medication a controlled substance? ☐ No ☐ Yes
Who will store this medication on campus (please check one): ☐ School Nurse ☐ Teacher/Year Tutor ☐ Student		
SECONDARY ONLY Can the student self monitor their condition and self administer this medication without staff supervision? ☐ Yes ☐ No		
Possible Side Effects:		

Prescribing Health Care Provider's Information:

Stamp, Print, or Type Health Care Provider's Name and Address:	Office Phone Number:

Section below to be completed by child's parent or guardian:

I give permission for my child,_____,to be given the above medication as prescribed. I give permission for the school nurse, or other school staff caring for my child, to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school may require that I agree to the school's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school of my child's medications change in any way.

Signature of Parent / Guardian

Date

Print or Type Name of Parent / Guardian

Day Phone Number