Public Health Protection Department- School Health Section

Parental/Guardian Consent & Medication Record to Administer Prescribed Medication

Student Full Name:_____	**D.O.B:**_____	**Age:**_____
EMIRATE ID:_____	**Student ID:**_____	**Gender:** ☐ Male ☐ Female
School Name:_____	**Grade:**_____	**Nationality:**_____
Treating physician details: Name:_____ Workplace:_____ Contact No:_____	**Allergy Status:**_____ **Medical Diagnosis/ condition:** _____	
Medication Name :_____	**Medication Strength:** _____	**Expiry Date:** _____
Dose:_____ **Frequency:**_____	**Start Date** _____	**End Date:**_____
Route for administering the medication: ☐ By mouth ☐ Injection ☐ Inhalation ☐ Topical ☐ Other: (specify)_____	**What time does medication need to be given at school?** _____AM _____PM	

Any precautions/ contraindications that school personnel need to know?

_____

To ensure student safety. School Medical staff is responsible to read the instructions in original prescription prior to completing the record & adhere to the principles of drug administration.

Please attach the copy of original prescription.

school medical Team (name & license ID): _____

Signature: _____Date:_____

I understand it is my responsibility to send the medication to school in the original pharmacy container labeled with my child's name, treating physician's instructions/care plan and provide the original prescription and any other documentation to assist in the safe administration of the specified medications.

Parent/Guardian-Full name: _____

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Parent/Guardian signature: _____Mobile No:_____Date_____

Student Full Name:_____				**Student ID:**_____	**Hasana ID:**_____
Medication Name: _____				**Emirates ID:**_____	
DATE	**TIME**	**DOSE**	**ROUTE**	**NAME OF STAFF & SIGNATURE**	**NOTE**