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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

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