DSC International School
德思齊加拿大國際學校

STUDENT MEDICATION CONSENT FORM

Student Name:	**Class:**	**HR Teacher:**
Parent #1	Name:	Phone Number:
Parent #2	Name:	Phone Number:

Medication Details:

Name of Medication:	Dose: _____ tablets/ pills/ capsules or _____ mls/ drops/ spray	Time/Frequency: Every _____ hrs _____ times a day
Medical Condition:	Route: Oral/ Eye/ Ear/ Skin (cream/lotion)	Side Effects:

I will supply the health room with the medication:

(a) once a day
(b) once a week
(c) once a month
(d) as necessary

Medication must be stored in the original container. The name of the student, the name of the medication, the dosage, time, and route of the medication must be stated on the container.

I, the undersigned, the parent/guardian of _____, give consent for
Student's Name
the Health Room Staff to assist/supervise my child with taking his/her medication.

If the Health Room Staff are absent from school I give permission for an office staff member or student's teacher to assist my child with taking his/her medication.

Notes:

_____ _____ _____ / _____
DATE Signature of Parent / Guardian Relationship

_____ _____
DATE Signature of Health Room Supervisor