EMERGENCY MEDICATION AUTHORISATION

SCHOOL YEAR ____/_____

Name of child ____________________________________

Grade ____________________________________

An Action Plan (anaphylaxis, asthma, epilepsy) for my child including a picture is attached to this document. (please tick if appropriate)

	MEDICATION	HOW TO BE TAKEN	DOSAGE	SYMPTOMS	EXPIRATION DATE
1					
2					
3					
4					

I/We ____ (name and surname of mother and father) hereby request the school nurse or staff of MSF to administer or observe the administration of the above mentioned medication in case of emergency. I/We will notify the school, in writing, of any changes in medication.

I/We, the parent/s or legal guardian/s, agree to release MSF and its staff members from lawsuits, claims, expenses, demands or actions etc. against them for helping this student to use medication, provided by MSF staff members comply with the physician, parent or guardian orders set forth in accordance with the provision of this authorisation.

Specific instructions: ____________________________

Specific storage: ____________________________

Place/date ____________________________________

Signature (mother) _________________________________

Signature (father) _________________________________