MEDICATION AUTHORISATION
SCHOOL YEAR _____

Child's name_____

Grade _____

Medication _____

Dosage (ml or mg) _____

How to be taken (orally, ...) _____

▫ Daily during the school year OR ▫ from _____ to _____ (dd/mm/yy)

Medicine should be given at the following time(s)_____

Specific instructions _____

Specific storage _____

Please attach the prescription, medication will not be administered without a doctor's prescription.

I/We _____ (name and surname of both mother and father) hereby request the school nurse or a member of MSF staff to administer or observe the administration of medication as directed in this document. 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 MSF staff members comply with the physician, parent or guardian orders set forth in accordance with the provisions of this authorisation.

Date_____ Mother's Signature_____

Date_____ Father's Signature_____