MERRYLAND INTERNATIONAL SCHOOL
ABU DHABI, UNITED ARAB EMIRATES

PARENTAL CONSENT TO ADMINISTER PRESCRIBED MEDICATION

PART -1 (TO BE FILLED, SIGNED AND STAMPED BY HAAD LICENSED PHYSICAN)

Student name:		Date of birth:	
Health condition for which the medicine is prescribed:			
Name of medication:		Dose:	
The medication to be continued until:			
Route for administering the medication			
◯ By mouth	◯ Injection	◯ Inhalation	◯ Topical	◯ Other: (please specify)
What time does the medication need to be given at school?			
Any precautions that school personnel need to know?			
Any contraindications that school personnel need to know?			
What are the possible reactions/ side effects?			
What should be done in the event of reaction/ side effect?			
Check appropriate box below:			
☐ I authorize this student to self- administer the above medication. ☐ The above medication can only be administered by a HAAD Licensed School Nurse.			
Name, address, phone number of Healthcare Provider		Signature of the treating physician prescribing the medication	

Part 2 (TO BE FILLED AND SIGNED BY PARENT):

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 any other documentation to assist in the safe administration of the specified medications.

I give my permission for my child to take the prescribed medication while at school. I hereby acknowledge that I have read and understood the school clinic's policy. I hereby release Merryland International School and its employees from any claim or liability connected this medication permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with this medication permission.

Parent Name:	Signature:	Date: