美国国际教育联合会
American International
Education Associates
P. O. Box 231, Andover, MA 01810, U.S.A.

Consent For Medication Administration

Name of Student ______________________ DOB ______________________

Grade _______________ School ______________________________

Address ______________________________________ Tel: ______________________

Medication Order: (to be completed by a licensed prescriber)

Diagnosis ______________________________ Other Medical Conditions _______________

Medication_______________ Dosage _______________ Route ________

Frequency ________________

Duration ______________________________ Side Effets ______________________

Special Instructions ______________________ Consent for self-administration _______________

Signature of Licensed Prescriber ______________________ Date _______________

Name of Licensed Prescriber (please print) ______________________ Tel. # ______________________

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Parent /Guardian Permission:

________ I request that the program persnonel administer this medication to my child.

________ I give permisson for my child to self-administer this medication

Parent/Guardoam Signature ________________ Date: ______________