

SHA TIN JUNIOR SCHOOL

Authorisation Form for Emergency Prescribed Medication

Student's Name _____

Last

First

Middle initial

Date of Birth _____ Year & Section _____

It is necessary for the following medication to be administered urgently during school hours in the form and dosage specified below, in order to maintain this child's physical health.

Name of medication _____

Dosage to be given _____

Possible side effects/ Adverse reactions _____

I hereby grant permission for the School Health Professional or deputy, to administer the above medication to my child and to communicate with my child's physician when it's necessary with regard to this medication. I agree that the medication has to be taken for emergency.

Parent/ Guardian's Signature _____ Date _____

TO BE COMPLETED BY THE PHYSICIAN

Name of patient _____

Diagnosis for which medication is prescribed _____

Name of medication _____

Dosage (Be specific, i.e., milligrams, etc) _____

Precautions, reactions or side effects _____

Printed Name

Signature

Date

Contact No. _____