

BRITISH EMBASSY STUDY GROUP
MEDICATION ORDER FORM
(for UK prescribable medicines)

PART A - ALL SECTIONS TO BE COMPLETED BY A LICENSED PRESCRIBER

Name of Student _____ Date of Birth _____

Name of Licensed Prescriber _____

Business Telephone Number _____ Emergency Telephone Number _____

Generic Name of Medicine _____

Route of Administration _____ Dosage _____

Frequency _____ **Time(s) of administration** _____

Specific directions / information for administration _____

Date of Order _____ **Discontinuation Date:** _____

Diagnosis _____

Any other relevant medical condition(s) _____

Optional Information

Special side effects, contraindications, or possible adverse reactions to be observed: _____

Other medication recently taken by the student: _____

The date of the next scheduled visit or when advised to return to prescriber: _____

Signature of Licensed Prescriber _____ **Date and Stamp** _____

PART B - TO BE COMPLETED BY PARENT/GUARDIAN

All sections to be completed

I request and consent to have the School Nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to _____
Licensed Prescriber Student Name

I request the medicine be given at the following dates and times:

Start date _____ **Stop date (eg. last day)** _____

Times to be given _____

Any other instructions _____

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate:

YES NO (please circle)

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

Parent/Guardian Name _____ Relationship to student _____

Signature _____ Date _____

Please note

- Medicine must be brought to school by parent and NOT sent with the child.
- Medicine must be brought in its original clearly labelled container