BRITISH EMBASSY SCHOOL ANKARA
OVER THE COUNTER MEDICATION
PARENT/GUARDIAN INSTRUCTION FORM

Medicine must be brought in by parent and NOT sent with child

Name of Student _____ Date of birth _____Class_____

Parent/Guardian printed name _____

I request and consent for my son/daughter to be given the following medications by the school nurse or school personnel designated by the school nurse, which I have sent in its original container, **correctly labeled**

Name of medicine _____

Dosage to be given each time _____

Times that medicine is to be given _____

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Start Date _____Stop Date (e.g. last day of administration) _____

Has the medicine been given before? YES NO

Is the child receiving any other medicines? (If so please state which) YES NO

Name and reason for giving this medicine _____

Are you aware of any current or possible side effects? If so, please list

_____

My son/daughter has the following food or drug allergies:

_____

I request and consent to have the School Nurse or school personnel designated by the School Nurse administer the medicine, which I understand will be given at the nurse's discretion

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

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.

I understand I may retrieve the medication from the school at any time, however, the medication will be destroyed if it is not picked up within one week following termination of the order or by the end of the school year, whichever is the earlier.

_____ _____ _____
Full name (Please print) Signature Date

PLEASE NOTE - FORM MUST BE COMPLETED IN FULL