



Christian Alliance International School Medication Consent Form

I, _____, the parent/guardian, of _____ (Student's name & Class) give the permission to the school nurse or designated staff to administer the following medication(s).

I also give permission to the school nurse to contact my physician/ dentist if necessary.

Medication	Dose to be given	Time to be given	Reason(s)	Possible side effect(s) that require to be reported	Starting Date	End Date

Instruction:

Is refrigeration required? Yes No

Should medicine be sent home with the student each day? Yes No

Other instruction:

By signing this consent, I authorize the school nurse or designated staff to administer the above medication(s) to my child according to my instruction and I understand that the school would not have the liability for any side effects that may be caused by the medication(s).

Parent/Guardian's Signature: _____

Contact number: _____

Date: _____