BRUSSELS AMERICAN SCHOOL
PSC79/BAS, APO AE 09714
HEALTH OFFICE

MEDICATION DURING SCHOOL HOURS

Name of Student _____ Grade_____

Diagnosis _____

Medication _____ Dosage _____

Time _____ Route _____ Duration _____

Possible side effects _____

Precautions/Restrictions _____

Other medications taken _____

Clinic _____ Phone number _____

Date _____ _____

Signature of Physician

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I hereby give my permission for _____
to take the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication.

Date _____ _____

Signature of Parent/Guardian

Parent daytime phone number #1_____ #2_____

NOTE: ***The prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage and the date issued. The medication will remain at school for the duration of the prescription.***