EXCELSIOR
INTERNATIONAL

MEDICINE ADMINISTRATION FORM (EIS/MY/CLN/MAF)

(Updated as at 20th September 2011)

Name of student: …… **Class**: ……

Homeroom Teacher: ……

Type of medicine:

☐ Prescription ☐ Non-prescription or over-the-counter

Note: All medications must be stored in their original pharmacy-labelled containers, and in such manner as to render them safe and effective. Information such as the child's name, name of medication (if applicable) and clear directions for administration must be available.

Instructions:

Name of medicine	Reason for medication	Dosage	Frequency and period of medication	Time of administration or other instructions

I give my permission for the School Nurse and other delegated EIS employees to administer the above-mentioned medicine(s) to my child. In addition, in the interest of my child's well-being, I accord the permission to the School Nurse to exchange health information with the health care provider^ listed below, or other EIS Teachers or employees about the medication(s) he/she is receiving.

…….. …….. ……..

Print name and sign *Relationship with student* *Date*

Physician information^:

…….. …….. ……..

Print name and sign *Date* *Contact details and company stamp*

^ For medicine administration that exceeds 15 consecutive days, it is mandatory that the physician or health care provider endorse this form.