

PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL

Student Name: _____

School: _____

In order for the school to administer any prescription or over-the-counter medication to your child, you must provide the school with written orders from your child's healthcare provider. All medications must be provided in their original container and labeled with your child's name. Please return this form to:

Name: _____

Title: _____

Phone/e-mail: _____

By signing this form, I give permission for my child's healthcare provider to share information about the administration of this medication with the school staff delegated to administer medications. I further authorize the school personnel delegated to administer medications to administer the medication(s) identified in the following section in accordance with my healthcare provider's instructions.

Parent/guardian's signature: _____

Printed name of parent/guardian: _____

Date: _____

This section must be completed by your healthcare provider

HEALTHCARE PROVIDER AUTHORIZATION

CHILD'S NAME:

Birth date:

Medication:

Dosage:

Route:

Administration time(s):

Start Date:

End Date:

Special instructions:

Any side effects to reported:

Signature of healthcare professional with prescriptive authority: _____

Printed name of healthcare professional: _____

Phone/e-mail: _____

Date: _____

RUHUSA YA KUPEWA DAWA SHULENI

Jina la Mwanafunzi:

Shule:

Ili shule iweze kumpa mtoto wako dawa iliyoagizwa na daktari au dawa ya dukani, ni lazima uipe shule maagizo yaliyoandikwa kutoka kwa mtoa huduma ya afya wa mtoto wako. Lazima dawa zote ziletwe kwenye kontena lao asilia na kuandikwa jina la mtoto wako. Tafadhali rejesha fomu hii kwa:

Jina:

Cheo:

Simu/barua pepe:

Kwa kutia saini kwenye fomu hii, ninaruhusu mtoa huduma ya afya wa mtoto wangu kushiriki maelezo kuhusu usimamizi wa dawa hii na wafanyakazi wa shule waliopewa mamlaka ya kusimamia dawa. Pia ninaruhusu wafanyakazi wa shule waliopewa mamlaka la kusimamia dawa zilizotambuliwa katika sehemu ifuatayo kwa mujibu wa maagizo ya mtoa huduma wangu wa afya.

Saini ya mzazi/mlezi:

Jina lililoandikwa la mzazi/mlezi:

Tarehe:

----- Lazima
sehemu hii ijazwe na mtoa huduma wako wa afya

IDHINI YA MTOA HUDUMA YA AFYA

JINA LA MTOTO:

Tarehe ya kuzaliwa:

Dawa:

Kipimo:

Njia:

Saa ya kupewa:

Tarehe ya Kuanza:

Tarehe ya Mwisho:

Maagizo Maalum:

Madhara yoyote ya kuripotiwa:

Saini ya mtaalamu wa huduma ya afya aliye na mamlaka ya maagizo:

Jina lililoandikwa la mtaalamu wa huduma ya afya:

Simu/barua pepe:

Tarehe: