REQUEST FOR THE ADMINISTRATION OF DRUGS DURING THE SCHOOL HOURS

To the school manager
of IC Grazzanise

I undersigned _____ parent/tutor/trustee of the student _____ born in _____ on ___/___/___, who lives in _____ enrolled in the class _____ of the:

- ☐ Primary school, building _____
- ☐ Secondary school, building _____

Aware that the school staff doesn't have the medical duties,

According to the medical certification and the treatment plan here attached, released by

the ASL _____/ by the Dr_____

on ____/____/____;

ASK

Also on behalf of the other parent

- ☐ That my child can receive the drugs specified in the treatment plan during the school hours

Or

- ☐ That my child, able to take drugs on his/her own, can take those specified in the treatment plan during the school hours

I authorize the school staff to give the drugs specified in the treatment plan and release the school from any liability.

I will provide my child with the proper drugs paying attention also to their expiry date (considering that if they are expired, they won't be taken by the child).

In addition, I will provide school manager with the updated documentation and medical certifications useful for the medical therapy.

Telephone n. of the family: _____

Telephone n. of the doctor: _____

I agree to the use of personal data according to the EU Guidelines 2016/679 and ex Lgs D n 196/03.

Aware of penalty in case of false declaration or use of false acts as stated in the article 46 of D.P.R. n. 445/2000, I declare to respect the parental responsibilities specified in the art 316,337 ter and 337 quarter of the c.c.

Place and date

In witness
(sign legibly, in full)