Bridgewater-Raritan Regional School District

Parent Request for Administration of Non-Prescription Medication
Acetaminophen, Ibuprofen, Mylanta, Tums only

School Year: _____

Name of Student: _____ School: _____

Medication: _____ Dose: _____

Reason for medication: _____

I give permission for the School Nurse to administer to my child the above medication as needed during school hours. I release the School Nurse and school district from any liability in connection with the administration of this non-prescription medication.

NOTE: Medication must be supplied by the parent/guardian in the original container.

Parent/Guardian signature: _____ Date: _____

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Nurse signature **Initials** **Nurse signature** **Initials**

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