PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837

MEDICATION ADMINISTRATION

Dear Parent/Guardian:

Medication shall be administered only upon written order of the prescribing physician and a written request of the parent. This will give permission for the nurse to administer the medication as directed.

Medication shall be given to the nurse **only** in a **currently** labeled prescription bottle.

TO BE COMPLETED BY PHYSICIAN

Student: _____ Date: _____

Diagnosis/Purpose: _____

Name of Medication: _____

Dose: _____

Specific time(s) to be given: _____ **(Daily or PRN) (circle one) am / pm**

Special circumstances of administration **(if PRN, specify frequency**): _____

Dates of Administration: _____

Specify **reportable** side effects: _____

_____ _____
Name of Physician **(print)** Signature of Physician

_____ _____
Address of Physician Date

(_____)_____
Telephone # of Physician

TO BE COMPLETED BY PARENT/GUARDIAN

Student: _____ Date: _____

I hereby give permission to the school nurse to administer medication to my child as directed by the physician.

I release school personnel of all liability for the administration of medication as specified above.

_____
Signature of Parent/Guardian

_____
Date