

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

