# 2023-2024 Mandatory Medication Form

All medication (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the parent and physician.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's well being should be sent to school.

**Note: The first dose of any medication may **not** be given at school.**

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<table>
<thead>
<tr>
<th>Name of Student</th>
<th>DOB</th>
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</thead>
<tbody>
<tr>
<td>Name of Medication</td>
<td></td>
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<tr>
<td>Dosage</td>
<td></td>
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<tr>
<td>Time to be given</td>
<td></td>
</tr>
<tr>
<td>Reason for Medication</td>
<td></td>
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<tr>
<td>Medication to be given from</td>
<td>to</td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>How it is taken</td>
<td>EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.</td>
</tr>
<tr>
<td>Additional Comments</td>
<td></td>
</tr>
</tbody>
</table>

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**Parent Signature/Date**

**Physician Signature/Date**

**Telephone Number**
ADDITIONAL MEDICATIONS

NAME OF STUDENT ___________________________ DOB __________

NAME OF MEDICATION _______________________________________

DOSAGE __________________________________________________

TIME TO BE GIVEN __________________________________________

REASON FOR MEDICATION ___________________________________

MEDICATION TO BE GIVEN FROM __________________ TO __________

DATE TO DATE______________________________________________

HOW IT IS TAKEN ___________________________________________

EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _______________________________________

NAME OF STUDENT ___________________________ DOB __________

NAME OF MEDICATION _______________________________________

DOSAGE __________________________________________________

TIME TO BE GIVEN __________________________________________

REASON FOR MEDICATION ___________________________________

MEDICATION TO BE GIVEN FROM __________________ TO __________

DATE TO DATE______________________________________________

HOW IT IS TAKEN ___________________________________________

EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _______________________________________

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PARENT SIGNATURE/DATE ____________________ PHYSICIAN SIGNATURE/DATE ______________________

TELEPHONE NUMBER __________________________ TELEPHONE NUMBER __________________________

11/4/2016 ESC of Morris County