# Ocean Township High School

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***SPARTAN MISSION:***
*Meeting the needs of all students with a proud tradition of academic excellence.*

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*MEDICATION FORM*

_____is being treated for
Name of Student

_____and is to be given
Illness

_____**at**_____
**Name of Medication** Time(s)

_____
Dosage Period of Time to be Administered

Contraindications for the administration would be_____

Possible Side Effects_____

_____

_____ _____
*Physician's Signature* *Date*

**I request the above medication to be administered to my child.**

_____ _____
*Parent's Signature* *Date*

**Medication Drop off:**

_____ _____
**Parent's Signature** **Date**

**Medication Pick up:**

_____ _____
***Parent's Signature*** ***Date***

*Home of the Spartans!*
*#SpartanLegacy*