Medication Permission Form

Colts Neck Township Schools

Dear Parent / Guardian:

In order for any medication to be administered to your child there shall be on file in the school health office a written order from your physician which identifies the name, dosage, purpose, side effects, and any contraindications to the medication. We must also have written permission from the parent / guardian giving consent to administer the medication during school hours. This form must be completed and returned to the school nurse.

Medication must be in original prescription bottle/container and brought to the health office by the parent or guardian. Children should not be transporting medication with them to school for the students' safety and the safety of others.

Thank You

The Health Office

Parent / Guardian Permission Request

I hereby request that my child _____ be administered medication during school hours as prescribed by his/her physician. The physicians written orders must accompany this request. I authorize the school nurse to administer the medication and release and indemnify those persons and the school district from any liability in connection with the administration of the medication.

Date _____ Signature of Parent _____

Recommendations of Physician

It is necessary for _____ to have the following medication in school.

_____ Please check if applicable: I give permission to withhold this medication on *class trips* and short *session days*.

Medication: _____ Diagnosis: _____

Dosage: _____ Time of Administration: _____

Purpose of Medication: _____

Ill effects that may occur if medication IS NOT given: _____

Signs of medication overdose and or contraindications: _____

I give permission for the school nurse and / or authorized personnel of the school to administer the above medication.

Date: _____ Signature of Physician: _____

office stamp