Monmouth County Vocational School District

ADMINISTRATION OF MEDICATION IN SCHOOL

Physician Prescription/Parent Permission Form

School Building _____ Home HS _____

Teacher _____ Grade _____

_____(student name) is to be given

_____(medication) _____(dose) at _____(time)

Daily _____or PRN (as needed) _____

Diagnosis _____

Possible side effects are _____

_____

Period of time to be administered _____

_____(print name of student) is physically fit to attend school and is free of contagious disease **and** would not be able to attend school if the medication is not administered during school hours.

_____ _____

Physician's Signature Date

Physician Stamp: Physician Phone Number _____

Be advised that the district shall incur **NO** liability as a result of any injury arising from the administration of medication and that the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of this medication.

This permission is effective for the school year for which it is granted and must be renewed for any subsequent school year.

I request that the school nurse administer the above medication to my child.

_____ _____

Signature of Parent/Guardian Date

Revised 1/28/16