

Southern Regional School District
OCEAN COUNTY, NJ

MEDICATION PERMISSION FORM
FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

Student's Name: _____ **DOB:** _____ **ID#:** _____

Notes to Parents/Guardians:

- No medication (including Tylenol, Advil, etc.) can be administered to a student without written permission from a physician and a parent/guardian.
- If your physician decides it is necessary for your child to receive medication during school hours, please have this form completed by him/her.
- Medication must be brought to the nurse's office in the original pharmacy bottle in which it was dispensed or in the original over-the-counter packaging/bottle it was purchased in for non-prescription medications. Prescription medications must be labeled with the student's name, dosing directions and frequency. Over-the-counter medications must be unopened and have the student's name on the outside of the package or container.

TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN:

Date of Order _____ Diagnosis _____

Medication _____ Dosage _____

Time and Circumstance to be administered in school _____

Restrictions on student activities _____

I certify, as the attending physician for this student, that possible adverse reactions and potential side effects have been explained to both the student and parent/guardian.

Physician's Signature _____ Date _____

Office Stamp

Parental Consent for Administration of Medication

I hereby give permission for my child to receive medication at school as prescribed above. In addition, I understand that this information will be shared with school staff on a need to know basis. I am fully aware of the possible adverse reactions and potential side effects of the medication prescribed. The Southern Regional School District shall incur no liability as the result of any injury or claim that arises as a result of my child having been prescribed and administered this medication as ordered.

Parent/Guardian Signature _____ Date _____