429 Joyce Kilmer Ave, New Brunswick, NJ 08901
T: 732.448.1052 F: 732.448.1055

Medication Administration in School Permission Form

↓↓↓ To Be Completed By The Parent / Guardian ↓↓↓

Student Name: ____ DOB: _________________

In response to the request that your child receive medication during school hours, this form must be completed and returned to the Health Office. It gives permission for the school nurse to administer the medication according to written instructions from the PHP (Primary Healthcare Provider).

I request that my child, ____ be administered medication as prescribed by the PHP.

I agree that this information may be shared with GBCS School staff as appropriate. I relieve Greater Brunswick Charted Schools and its employees from liability for administration of medication.

____ Date: _________________
Print Name of Parent / Guardian

____
Signature of Parent / Guardian

+ +

↓↓↓ To Be Completed By The PHP (Primary Healthcare Provider) ↓↓↓

I request that the above named student be administered the following medication:

Diagnosis: ____

Medication: ____

Purpose of Medication: ____

Dosage: _____________________________________ **Route**: ________________________________

Time / Frequency: ____

Start Date: _______________________________ **End Date**: _________________________________

Potential Side Effects: ____

____
PHP Name (Print)

____
PHP Name (Signature)

Date: ______________________________________

Address, Phone # or Office Stamp: