

BRIGANTINE PUBLIC SCHOOL DISTRICT
HEALTH OFFICE

(609)266-3603 phone _____ (609)266-7062 fax

MEDICATION IN SCHOOL PERMISSION REQUEST FORM

To be read and completed by parent or guardian.

For medication to be administered during the school day, the Brigantine Public School District requires the following:

1. Present completed written consent form signed by parent/guardian.
2. Bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

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Name of student _____ Grade/class _____

Date of birth _____ School ___ Elementary ___ Middle

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TO BE COMPLETED BY PHYSICIAN / N.P.

Name of medication(s) _____

Purpose of medication(s) _____

Specific time(s) / circumstance(s) & dose(s) to be given at school _____

Length of time _____

Possible side effects & action to be taken _____

Are there any restrictions? ___ Yes ___ No. If yes, what & for how long?

Printed name of Physician / N. P.
Address _____

Signature of Physician / N.P.
Date _____

Phone _____

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TO BE COMPLETED BY PARENT / GUARDIAN

I give my permission for my child to receive the medication as directed. I understand that the Brigantine Board of Education & its employees assume no liability for the administration of this medication. My child has been instructed about the medication and will be responsible to go to the school health office at the designated time(s) to receive the medication.

Signature of Parent / Guardian

Date _____

Phone (home) _____

Phone (work) _____