Milltown School District
Milltown, N.J. 08850
Health Office

REQUEST FOR MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE

Physician's Statement **School Year** ______________________________

In order to protect the health of __________________________________ it is necessary for him/her to have the following medication during school hours:

Diagnosis ____

Medication____

Dosage/Route/Frequency____

Time ________________________Purpose ____________________________________

List any side effects than can be expected ______________________________________

____

Daily medication to be given on field trips Yes ☐ No ☐
Daily medication to be given on half days Yes ☐ No ☐

I authorize the school nurse to administer the above medication.

____ _________________________
Physician's Signature Date

____ _________________________
Physician's Printed Name Phone Number

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Parental Permission

I authorize my physician and his staff to release the information required to complete this medication form so my child can receive medication during school hours. I release the Milltown Board of Education and its employees of any liability that may result from the administration of this medication to my child. I authorize the school nurse to administer this medication to my child_________________________________ as directed by my physician.
Printed name of child

____ __________________________
Parent's Signature Date

____
Parent's Printed Name