MILLVILLE PUBLIC SCHOOLS
MEDICATION ADMINISTRATION FORM

Parent Completes: Date: _____

To Whom It May Concern:

I request that the school nurse administer _____ to my child

_____ during school hours as prescribed by the physician.

Medications may not be carried by students on their person unless they qualify under the policy for self-administration.

1. Please administer medications on schedule even on early dismissal day. _____Yes _____ No
2. I authorize the sharing of information, verbally and /or in writing, related to my child's health between the school nurse (or designee) and the healthcare provider listed below.
3. I authorize the sharing of information, verbally and/or in writing, related to my child's health between the school nurse (or designee) and school staff.
4. **I am aware that a parent/guardian must bring the medication to the school nurse and in its original, labeled container.**

_____ _____
Signature of Parent/Guardian Date

Physician Completes:

Authorization is hereby given for medication to be administered in school to:

_____ _____
Student Name Date of Birth

Diagnosis: _____
Medication: _____
Dosage and frequency: _____
Exact time student is to receive medication: _____ AM _____ PM
Length of time prescribed: _____
Possible side effects: _____
Other medications taken by student which might interfere with the effects of the ordered medication: _____
_____
Student needs to take medication while attending field trips: _____ Yes _____ No
Stimulant medication time(s) can be rescheduled to (time) _____ on field trip days.

_____ _____
Signature of Healthcare Provider Date

_____ _____
Signature of School Nurse Date