EGG HARBOR CITY SCHOOL DISTRICT
School Health Services
601 Buffalo Avenue and 730 Havana Avenue
Egg Harbor City, NJ 08215

PERMISSION FORM FOR A PRESCRIBED MEDICATION

Student_____ DOB/Age_____

Grade_____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____

Name, dosage and route of medication: _____

Instructions for schedule and dose to be followed at school: _____

Start and stop date: _____

Please describe restrictions and /or important side effects: _____

_____

Special Storage Requirements_____

Physician's Signature: _____ Date _____ Physicians Stamp

Address: _____

Phone Number: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child to receive the above medication as ordered. The parent/guardian shall indemnify and hold the district or its employees and agents harmless from any claims arising out of the administration of the medication.

All orders need to be prescribed annually and is the parents/guardians responsibility to schedule an appointment with the school nurse to pick up any unused medication on the last day of school or the medication will be properly disposed of.

Parent Signature_____Date_____