Monmouth Beach School

Form for administration of medication in school

(Over-the - Counter and Prescription Medication)

To be completed by Physician

Student Name: _____

Grade: _____

Name of Medication: _____

Dosage: _____

Time: _____

Daily: _____ **or PRN:** _____

Diagnosis: _____

Possible side effects: _____

Physician Signature: _____

Date: _____

Be advised that the district shall incur NO liability as a result of any injury arising from the administration of medication and that the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of this medication.

This permission is effective for the school year for which it is granted and must be renewed for each subsequent school year.

I request that the school nurse administer the above medication to my child.

Parent/Guardian's Signature: _____

Date: _____