

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

**REQUEST FOR GIVING MEDICATION AT SCHOOL
FORM 02-D-18**

This form is required for all over-the-counter and/or prescription medication(s) to be administered during school hours. The medication(s) will be supplied by the parents and brought to the school nurse in the original container appropriately labeled by the pharmacy and physician. **All medication must be picked up at the end of the school year.**

Student's Name: _____ Date of Birth: _____

Allergies: _____ Grade: _____ Current Weight: _____

Diagnosis/Medical Condition: _____

Name of Medication: _____ Dose to be administered: _____

Route: _____ Time to be administered: _____ am/pm (please circle)

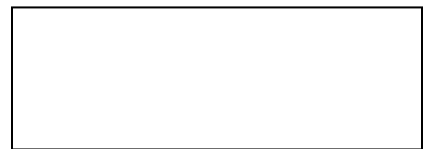
Possible side effects of medication: _____

Intervention to be rendered for an adverse reaction: _____

Dates to be dispensed (Please check): School year _____ to _____ Half days Field

Trips (including overnight trips) Other prescribed time period: _____

* _____
PHYSICIAN SIGNATURE DATE



* _____
PHYSICIAN PRINTED NAME

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

This section is to be completed by the Parent/ Legal Guardian

Please initial the following:

- I hereby give the school nurse/school physician permission to administer the above stated medication. Initial: _____
- I also, give the school nurse/school physician permission to contact my child's physician regarding the ordered medication, as needed. Initial: _____

Parent/ Guardian Signature Emergency contact number Date

Received by school and reviewed by _____ School Nurse-teacher
Name School Doctor
On _____
Date