ECLC OF NEW JERSEY HR_____

MEDICATION ADMINISTRATION PERMISSION- ***please complete one form for each medication***
Authorization for school nurse to administer medication in school and during off-property day and overnight trips

STUDENT NAME: _____DOB:_____

MEDICATION/AMOUNT: _____ DOSAGE:_____

TIME/S GIVEN: _____INDICATION:_____

Check appropriate option for community-based activities/field trips not attended by a school nurse:

_____Prescribed dose can be withheld during CBI/work/field trip with parent approval
_____ Administration time can be adjusted with parent approval

Physician's Name: _____ Phone: _____

_____ _____
PHYSICIAN'S SIGNATURE **DATE**

I give permission for the school nurse to administer prescribed medication to my child

_____ _____
PARENT/GUARDIAN'S SIGNATURE: **DATE:**

MEDICATION MUST BE IN THE PRESCRITPTION CONTAINER WITH THE CORRECT LABEL

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Int/Signature: _____ Int/Signature: _____ Int/Signature: _____