NORTH BRUNSWICK TOWNSHIP PUBLIC SCHOOL
MEDICATION PERMISSION FORM

Student_____ Grade_____ Teacher_____

Part I: To be completed by Physician

Diagnosis:_____

Medication Name_____ Dosage_____ Adm time_____

Duration of Medication(i.e. week, school year, etc.)_____

Restriction/Potential side effects: _____None anticipated

Yes. Please describe:

_____

_____

I certify that this student would not be able to attend school if this medication is not administered during the school day. _____(MD Initials)

MEDICATION INFORMATION/ADJUSTMENTS

If this medication is to be given on a regular basis, please indicate what needs to be done when the student is on a class trip or on early closing days. Teaching staff cannot give medications.

Check one:

___Student will not be taking the medication on the day of the class trip.

___Administer medication upon trip return providing it is within the normal school day

___Parent will assume responsibility for administering the medication.

Circle one:

Administer / Do Not Administer the medication on early closing days.

_____ _____

Medical Doctor Signature Date

Physician's Name:_____

Address:_____

Phone #:_____

PHYSICIAN STAMP

Part II: To be completed by parent/guardian

I give permission for (name of child)_____ to receive the above medication at school according to the medication policy of the North Brunswick Board of Education.

Parent Signature_____ Date_____

Parent Name (Print)_____

Relationship to child_____

This permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of the requirements stated in the NJSA 18A:40-12.5

PARENTS MUST PICK UP THEIR CHILD'S MEDICATION BY THE LAST DAY OF SCHOOL OR THE MEDICATION WILL BE DISCARDED.