

PERMISSION TO ADMINISTER MEDICATION

Please complete form and send into school whenever you require the school nurse to administer prescription or over-the-counter medications to your child. Additional forms are available.

In order to protect the health of _____,
it is necessary for him/her to have the following medication during school hours:

Medication: _____

Dosage: _____

Time to be administered: _____

Purpose of medication: _____

Length of time prescribed: _____

Possible side effects: _____

This medication is:

_____ prescription medication

_____ over-the-counter medication

Parent/ Guardian Signature

Date

Physician's Signature

Date

Recommendations are effective for one school year only and must be renewed annually.

Please return to:
The Wilson School
271 Boulevard
Mountain Lakes, NJ 07046
Attn: School Nurse