

Monmouth County Vocational School District
ADMINISTRATION OF MEDICATION IN SCHOOL
Physician Prescription/Parent Permission Form

School Building _____ Home HS _____

Teacher _____ Grade _____

_____ (student name) is to be given

_____ (medication), _____ (dosage) at _____ (time)

Daily _____, or PRN (as needed) _____

Diagnosis _____

Possible side effects are: _____

Signature of Physician/Stamp

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 any subsequent school year.

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

Signature of Parent/Guardian

Date