MANDATORY MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student’s name, medication, dosage and physician’s name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student’s name.
- **Written permission** of the student’s physician and parent/guardian are required, including the student’s name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student’s wellbeing should be sent to school.

**NOTE: THE FIRST DOSE OF ANY MEDICATION MAY NOT BE GIVEN AT SCHOOL.**

NAME OF STUDENT_________________________________DOB________________

NAME OF MEDICATION_________________________________________________

DOSAGE_______________________________________________________________

TIME TO BE GIVEN______________________________________________________

REASON FOR MEDICATION______________________________________________

MEDICATION TO BE GIVEN FROM____________________TO_________________

DATE                                                     DATE

HOW IT IS TAKEN_______________________________________________________

EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_________________________________________________________________

______________________________________________     ___________________________________________

PARENT SIGNATURE/DATE       PHYSICIAN SIGNATURE/DATE

_______________________________ _____________________________

TELEPHONE NUMBER    TELEPHONE NUMBER
ADDITIONAL MEDICATIONS

NAME OF STUDENT _______________________________  DOB ____________

NAME OF MEDICATION ____________________________________________

DOSAGE __________________________________________________________

TIME TO BE GIVEN ________________________________________________

REASON FOR MEDICATION __________________________________________

MEDICATION TO BE GIVEN FROM __________________ TO ______________

DATE ____________________  ______________________

HOW IT IS TAKEN __________________________________________________

EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS ____________________________________________

NAME OF STUDENT _______________________________  DOB ____________

NAME OF MEDICATION ____________________________________________

DOSAGE __________________________________________________________

TIME TO BE GIVEN ________________________________________________

REASON FOR MEDICATION __________________________________________

MEDICATION TO BE GIVEN FROM __________________ TO ______________

DATE ____________________  ______________________

HOW IT IS TAKEN __________________________________________________

EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS ____________________________________________

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PARENT SIGNATURE/DATE                           PHYSICIAN SIGNATURE/DATE

__________________________________     ____________________________

TELEPHONE NUMBER                                             TELEPHONE NUMBER

11/4/2016 ESC of Morris County