FRANKLIN TOWNSHIP PUBLIC SCHOOLS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student:	Г	OOB:	Grade/Teacher:
Part I: To Be Completed By Phys	<u>ician</u>		
Name of Medication:			
Dosage:	Route:	Tim	e of Administration:
Indication:	3		
Side Effects/Restrictions:	=		
If this medication is given on a ropening/early dismissal days or		se indicate w	hat needs to be done on delayed
Parent will administer medica	tion on delayed op	ening or early	dismissal days.
The prescribed dose of medica	ation can be withhe	eld on the day	of the class trip.
Signature of Physician	·	Date	
Name of Physician (Print)			
Physician's Stamp:			
Part II: To Be Completed by Pare	ent/Guardian		
their health care provider in accor- administration of the medication is may require their presence at anot the school district, agents and its e arising from the administration or	dance with N.J.A.C. s mine, and I am fu ther location at the mployees shall inc lack of administra chool District, its a	: 6A: 16-2.3. In the state of the state of the state of the state of the median of the mediants and empty	d above during school hours as ordered by inderstand the ultimate responsibility for the duties of the school nurse and others medication is needed. I understand that as a result of any condition or injury dication prescribed on this form. I bloyees against any claims arising out of
Signature of Parent/Guardian		Date	
Name of Parent/Guardian (Print)			

THIS PERMISSION IS EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

Medications are to be brought to school by the parent/guardian in the **ORIGINAL CONTAINER** with a pharmacy label or in the original box for OTC medications and must be picked up at the end of every school year.