FRANKLIN TOWNSHIP PUBLIC SCHOOLS
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student:_____DOB:_____Grade/Teacher:_____

Part I: To Be Completed By Physician

Name of Medication:_____

Dosage:_____Route:_____Time of Administration:_____

Indication:_____

Side Effects/Restrictions:_____

If this medication is given on a regular basis, please indicate what needs to be done on delayed opening/early dismissal days or on class trips.

____Parent will administer medication on delayed opening or early dismissal days.

____The prescribed dose of medication can be withheld on the day of the class trip.

_____ _____
Signature of Physician Date

_____
Name of Physician (Print)

Physician's Stamp:

Part II: To Be Completed by Parent/Guardian

I request that my child be given the prescribed medication indicated above during school hours as ordered by their health care provider in accordance with N.J.A.C.: 6A: 16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

_____ _____
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.