

**Montgomery Township Schools**

Skillman, New Jersey  
School Health Service

**Medication Administration Request**

School Year: \_\_\_\_\_

Student name: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher / HR: \_\_\_\_\_ / \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Medication name: \_\_\_\_\_

Dose: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

**1. Daily Medication Schedule:**

Start date: \_\_\_\_\_ Stop date: \_\_\_\_\_

Administration Time(s): \_\_\_\_\_

Give only as needed

**2. Check any that apply:**

On early dismissal days, give medication at following time: \_\_\_\_\_

When delayed opening, give medication at following time: \_\_\_\_\_

For medications requiring school refills, email reminders should be sent to: \_\_\_\_\_

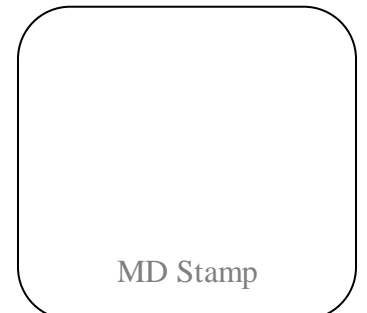
(Legibly print email address)

**Authorization to administer medication:**

I request that the aforementioned prescribed medication be given during school hours as ordered by my child's health care provider. I shall indemnify and hold harmless the district and its employee or agents against any claims arising out of the administration of medication directed by the parent or guardian.

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MD Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Staple Prescription Here

**Medication may only be transported to school by a parent / guardian.**

School Year: \_\_\_\_\_

MEDICATION RECORD

Name: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ HR: \_\_\_\_\_

Allergies: \_\_\_\_\_ Med: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE
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**Legend: A-Absent NS- No Show EC-Emergency Closing H-Holiday FT- Field Trip W- Weekend**

**Nurse Signature/Initials:**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_