

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: _____

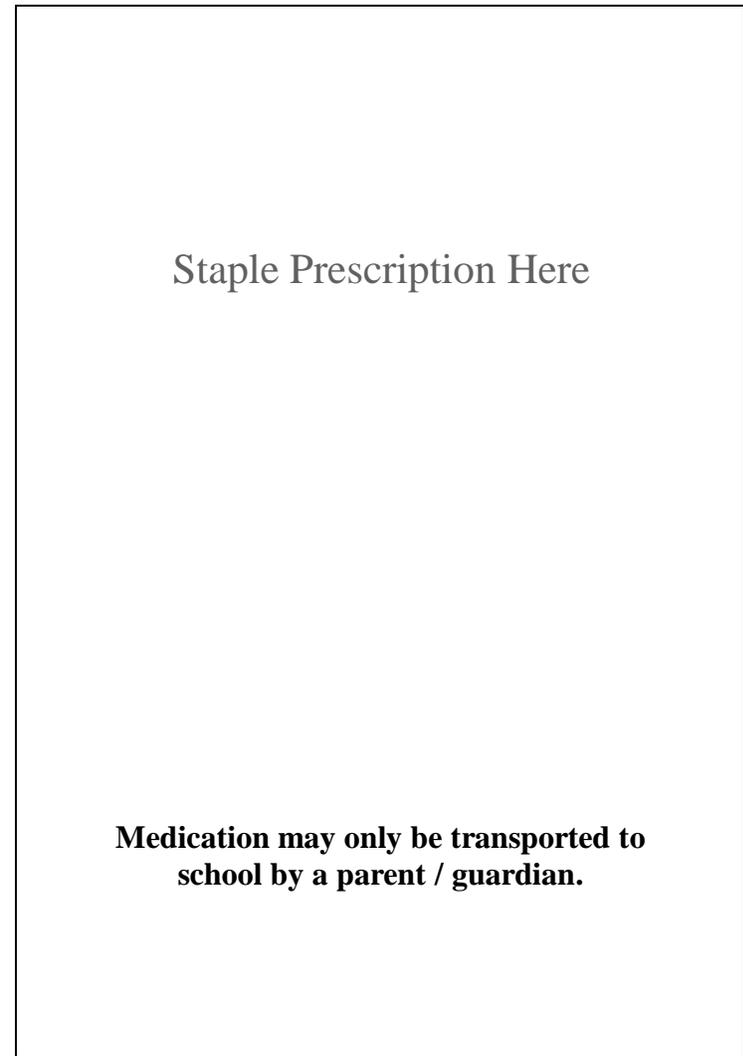
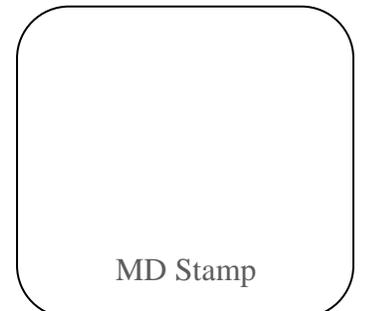
(Legibly print email address)

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: _____



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:

_____ / _____ / _____ / _____