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: _____

Staple Prescription Here

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

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:** _____

MD Stamp

Revised 5/2013

School Year: _____ MEDICATION RECORD

Name: _____ Teacher: _____ Grade: _____ HR: _____

Allergies: _____ Med: _____ Dose: _____ Time: _____

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Legend: **A-A**bsent **NS- N**o **S**how **EC-E**mergency **C**losing **H**-Holiday **FT- F**ield **T**rip **W- Weekend**

Nurse Signature/Initials:

_____/____ _____/____ _____/ ____

Revised 5/2013