TOWNSHIP OF FRANKLIN PUBLIC SCHOOLS
3228 COLES MILL ROAD
FRANKLINVILLE, NEW JERSEY 08322-3029

MEDICATION CONSENT FORM 2019 - 2020

If at all possible, parents are advised to give medication at home and on a schedule other than school hours. **IF IT IS NECESSARY** that a medication be given during school hours, these instructions must be followed:

1. Medication that is to be given by the school nurse must be brought to school by the parent, in the original container, with appropriate label intact. **MEDICATION MUST BE BROUGHT TO THE SCHOOL NURSE'S OFFICE AT THE BEGINNING OF THE SCHOOL DAY.**
2. Permission to dispense medication must be completed by the prescribing physician/dentist.
3. Permission to administer medication must be completed by the parent or the guardian.

Student's Name_____ **School**_____

Grade_____ **D.O.B.**_____ **Teacher's Name**_____

PART 1: TO BE COMPLETED BY PHYSICIAN/DENTIST

The school nurse may administer the following medication(s) to the above named student. This has been prescribed by me to treat:

ILLNESS/INJURY/CONDITION_____

MEDICATION_____

STRENGTH OF MEDICATION_____

DOSE(S) TO BE GIVEN_____

TIME(S) TO BE GIVEN_____

LENGTH OF TIME MEDICATION TO BE ADMINISTERED_____

POSSIBLE SIDE EFFECTS_____

_____ _____
SIGNATURE OF PHYSICIAN/DENTIST DATE SIGNED

_____ _____
PRINTED NAME OF PHYSICIAN/DENTIST OFFICE PHONE #

PART 2: TO BE COMPLETED BY PARENT/GUARDIAN

The school nurse has my permission to administer the above medication to my child as prescribed by Doctor_____, and has my permission to contact the physician/dentist, if necessary.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE SIGNED

_____ _____ _____
HOME PHONE # CELL # WORK PHONE #

(Please see page 2 and complete if applicable to your child)

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PART 3: TO BE COMPLETED BY PARENT/GUARDIAN AND PHYSICIAN, IF APPROPRIATE

I certify that _____ is capable of self-administering the
Student's Name

above identified medication and grant my permission for such self-medication.

It is understood that the Township of Franklin Board of Education shall incur no liability as a result of the above self-medication.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE SIGNED

_____ _____
SIGNATURE OF PHYSICIAN/DENTIST DATE SIGNED