Delaware Township School
PO Box 1000 – Sergeantsville, NJ 08557
Phone (609) 397-3179 Fax (609) 397-1485

Medication Dispensing Form

NOTE: MEDICATION BROUGHT TO SCHOOL MUST BE IN THE ORIGINAL CONTAINER.

Student's Name ______________________________ DOB __________ Grade _________________

Reason for Medication ____

Medication & Dosage ____

Times to be Administered ____

Possible Side Effects ____

Effective Dates: From ____________ To _____________

Class Trip Days:

_______ Dose may be omitted.

_______ Schedule may be adjusted. Please specify ______________________________________

Early Dismissal Days (12:50 P.M.):

________ Omit afternoon dose.

________ Maintain original schedule.

It is my understanding that the employees of the Delaware Township School charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment.

_____________________________________ _________________________________

Physician's Name & Signature Date

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Office Stamp

As parent/guardian of the above named child, I hereby request the administration of the medication described above to my child and release the Delaware Township School District and its employees from liability for damages my child may suffer as a result of this request.

_____________________________________ ___________________________________

Parent Signature Contact Number