HILLSIDE PUBLIC SCHOOLS
HILLSIDE, N. J.

REQUEST FOR MEDICATIONS TO BE ADMINISTERED IN SCHOOL

NAME OF PUPIL ______________________ GRADE ______ DOB: ______

ADDRESS ______________________

PARENT (S)/GUARDIAN ______________________

Emergency Telephone Number (s) ____________ / ____________

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MEDICATION ______________________

Dosage ______________________

Time/Circumstances of Administration ______________________

Duration ______________________

Purpose/Diagnosis ______________________

Restrictions : Physical Education ☐ Yes ☐ No restrictions

If yes, how long ______________________

Other ______________________

Physician's Name (Please Print) ______________________

Address ______________________

Telephone Number ______________________

PHYSICIAN'S SIGNATURE ______________________ Date ______

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PUPIL SELF ADMINISTRATION OF MEDICATION (PHYSICIAN'S CERTIFICATION)

I certify that the above named pupil is capable of and has been instructed in the proper use/method of administration and must be in possession of medication (as described above) at all times.

PHYSICIAN'S SIGNATURE ______________________ DATE ______

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PARENT/GUARDIAN CONSENT

The school nurse at ______________________ School has permission to administer the above medication to my child as prescribed by physician. We/I give permission to th school nurse to contact the physician if necessary. We/I also acknowledge that the district or its employees shall incur no liability as a result of the administration of the above medication or injury arising from the self administration of medication by e pupil and idemnify and hold harmless the district and its employees or agents against an claims arising out of the self-administration of medication by my child.

PARENT/GUARDIAN SIGNATURE ______________________ DATE ______

______________________ DATE ______