MADISON PUBLIC SCHOOL DISTRICT

359 Woodland Road • Madison, NJ 07940

Request for Administration of Medication by a School Nurse

School Year _____

Student's Name_____ DOB _____

School_____ Grade _____

Parent's Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

TO BE COMPLETED BY HEALTH CARE PRACTITIONER:

I certify that the above named student has the illness specified below, is physically fit to attend school, and is free of contagious disease. I further certify that the student will not be able to attend the school if the mediation is not administered during school hours.

Diagnosis_____

Medication _____

Dosage and time(s) to be taken _____

Date and time when medication should be discontinued _____

Possible side effects _____

Practitioners Stamp: Practitioner's Signature _____ Date

TO BE COMPLETED BY PARENT/GUARDIAN:

The parents/guardians hereby authorize the school nurse to administer the above as evidenced by our submission of the above Physician Certification. We undertand that the Board, its employees, or agents asahll incur no liability as a result of any injury arising from the administration of any medication to the pupil, and that we hereby indemnify and hold harmless the Board, its employees, or agents against any claims arising out of the administration of the medication by the staff.

Parent Signature: _____Date:_____

Parent Name: (please print)_____

School Nurse Signature_____Date:_____