East Greenwich Township School District
Medication Dispensing Form

The student listed below is under my medical care. His/her treatment requires dispensing medication during school hours as stated below:

Student's Name ____

Reason for Medication ____

Name of Medication ____ Prescription ( )
Non-Prescription ( )

Dosage___________________________ Time to be administered_____________

Effective dates from ________________ to ______________________

Route of Administration ______________________________________

Specific instructions ____

Precautions / Side Effects ____

It is my understanding that the school nurse, 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.

Date ______________ Physician's signature _____________________________

Address ____

Telephone ______________________________________

Parental Permission

Medication has been prescribed for my child, ____. As parent/guardian, I hereby request the administration of the medication described above to my child and release the East Greenwich Township School District and its employees of any responsibility or liability in giving this medication. I understand the medication brought to school must be labeled and in the original container. I also understand that if I am unable to accompany my child on school trips, the medication will not be given.*

Date _________ Signature of Parent / Guardian ____

____ I give my permission for the EGTS nurse to speak with my child's physician.

*** NB: NJ JERSEY STATE LAW ALLOWS CHILDREN TO SELF-MEDICATE FOR LIFE-THREATENING CONDITIONS ONLY. YOUR PHYSICIAN MUST CERTIFY IN WRITING, THAT THE PUPIL, THE PARENT/GUARDIAN, OR DESIGNATED ADULT IS CAPABLE OF ADMINISTRATING THE MEDICATION. CONTACT YOUR SCHOOL NURSE FOR THE "Emergency Medication on Field Trips" FORM.**