

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

**MEDICATION CONSENT FORM 2015 - 2016**

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