FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

REQUEST FOR GIVING MEDICATION AT SCHOOL
FORM 02-D-18

This form is required for all over-the-counter and/or prescription medication(s) to be administered during school hours. The medication(s) will be supplied by the parents and brought to the school nurse in the original container appropriately labeled by the pharmacy and physician. **All medication must be picked up at the end of the school year.**

Student's Name: ____ Date of Birth: _____________

Allergies: ____________________________ Grade: ________ Current Weight: _____________

Diagnosis/Medical Condition: ____

Name of Medication: ___________________________Dose to be administered: _____________

Route: ___________ Time to be administered:______________________ am/pm (please circle)

Possible side effects of medication: ____

Intervention to be rendered for an adverse reaction: _____________________________________

____

Dates to be dispensed (Please check): ☐ School year ______ to _______ ☐ Half days ☐ Field

Trips (including overnight trips) ☐ Other prescribed time period: ____________________

x____________________________ ____________________
PHYSICIAN SIGNATURE **DATE**

x____________________________
PHYSICIAN PRINTED NAME

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

This section is to be completed by the Parent/ Legal Guardian

Please initial the following:

- I hereby give the school nurse/school physician permission to administer the above stated medication. Initial: ___________
- I also, give the school nurse/school physician permission to contact my child's physician regarding the ordered medication, as needed. Initial: ___________

______________________________ ______________________________ ______________________
Parent/ Guardian Signature Emergency contact number Date

Received by school and reviewed by____ **School Nurse-teacher**
Name **School Doctor**

On _________________________.
Date

REV. 09/2022