

# FRANKLIN LAKES PUBLIC SCHOOLS

Woodside Avenue School  
305 Woodside Avenue Road, Franklin Lakes, New Jersey 07417

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Ann Jameson  
Principal

Noreen Carey RN, BSN, MPH, CSN  
Nurse

## MEDICATION PERMISSION FORM

**Medication orders are good for the school year in which they are written.**

Dear Parent or Guardian:

If it is necessary for your child to receive medication during the school day, please deliver it to the school in the **original pharmacy container with the label intact, along with this COMPLETED FORM signed by both the physician and the parent/guardian.** NOTE: It is recommended that the first doses of medication be administered at home if possible.

### Physician's Instructions

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Under my care for: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time To Be Given: \_\_\_\_\_ Duration: \_\_\_\_\_

Can a reaction be expected? Yes      No      If yes, please describe: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

### Parent's/Guardian's Notes

Administer this medication on early dismissal days?      Yes      No

Administer this medication on field trips?      Yes      No

My child has been instructed on and has my permission to carry and self-administer this medication.  
**(EpiPen and Inhalers only)**      Yes      No

I give permission to the school nurse to administer the above-prescribed medication. I hereby relieve the Board and its employees of any and all liability that may result from the administration of this medication to my child.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

