SALEM CITY SCHOOL DISTRICT
SALEM, NJ

HEALTH OFFICE
MEDICATION PRESCRIPTION NOTIFICATION

Date ____________

________________________________ has been prescribed the following medication (s):
Student Name

Medication | Dosage | Frequency

____

____

____

for the purpose of ____.

Possible side effects to this medication include:

____

____

____

PLEASE CHECK ONE:

________ Medication may be omitted during field trips.

________ Medication must be administered during field trips.

________ Medication may be administered when the child returns, if school is still in session.

School Year ________ Physician's Signature ______________________________

PARENTAL PERMISSION

I hereby give permission to the School Nurse to administer prescribed medication to:

____
Student Name

Prescription ________________________ Dosage ______________________________

Date ____________ Parent Signature ____

I agree to relieve the Salem City Board of Education and all of its employees from liability in the administering of medication.

Date ____________ Parent Signature ____

School Medical Inspector ____