THE EWING PUBLIC SCHOOLS
Nurse or Designee
Administration of Medication

Dear Parent/Guardian,

If it is necessary for your child to take any medication at school during school hours, you and your child's medical doctor are asked to complete the information below. Whenever possible, the taking of medication should be timed so that the medication is taken at home before and /or after school hours.

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School Nurse

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I hereby request permission for my child ____________________ a student at _________________ School to be given prescription or over the counter medication at school during school hours or while participating in school related activities. In doing so, I release The Ewing Public Schools' nurses, nurse designees and the Ewing Board of Education of any and all responsibility for any and all untoward reactions my child may incur as a result of taking said medication. I have obtained the following instructions from my child's physician.

To be completed and signed by physician:

1. Diagnosis ____

2. Medication ____

3. Dosage ____

4. Side effects of medication ____

5. Time during school hours ____

6. Beginning date is ____

7. Last day is ____

8. On days when field trips are taken:

   Medication may be waived ____ yes____ no

   Medication may be given when child returns to school
   ____ Yes____No

   Dosage can be adjusted (specify) ____Yes ____No

____________ ___________________________ ________________________________
Date Physician Signature Printed Name / Stamp

To be completed by parent:

I shall send the appropriate amount of medication in the original container to the school nurse.

I grant permission to share this health information with those staff members responsible for the care of my child.

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Parent Signature

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Approved by Medical Inspector
The Ewing Public Schools