EWING PUBLIC SCHOOLS
Nurse Administered Medication

Dear **P**arent/**G**uardian,

If it is necessary for your child to take any medication at school during school hours, would you and your child's medical doctor kindly fill out 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.

_____
School Nurse

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, and in doing so, release the Ewing School nurses, physicians, 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 filled in 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

To be filled in by parent:

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

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

_____
Parent Signature

_____
Approved by Medical Inspector
Ewing Public Schools