GBCS
Greater Brunswick Charter School

429 Joyce Kilmer Ave, New Brunswick, NJ 08901
T: 732.448.1052 F: 732.448.1055

Medication Administration in School Permission Form

To Be Completed By The Parent / Guardian

Student Name: _____ DOB: _____

This form must be completed and returned to the Health Office as per your request that your child receive medication during school. It gives permission for the school nurse to administer the medication according to written instructions from the Primary Healthcare Provider.

I request that my child, _____, be administered medication as prescribed by the Primary Healthcare Provider.

I agree that this information may be shared with GBCS School staff as appropriate. I relieve Greater Brunswick Charter Schools and its employees from liability for administration of medication.

_____ Date: _____
Print Name of Parent / Guardian

_____
Signature of Parent / Guardian

To Be Completed By The Primary Healthcare Provider

I request that the above named student be administered the following medication:

Diagnosis:_____
Medication: _____
Purpose of Medication: _____
Dosage: _____ **Route**: _____
Time/Frequency: _____
Start Date: _____ **End Date**: _____
Potential Side Effects: _____

Address, Phone # or Office Stamp:

_____
PHP Name (Print)

_____
PHP Name (Signature)

Date: _____