



School Street School
730 Birch Street - Boonton - New Jersey - 07005



School Medication Administration Form 2024-2025

Student Name: _____ **Grade:** _____ **Teacher/HR** _____

Physician Portion: Doctor must complete and sign this section.

Please administer medication to the above-named student with the following directions:

Purpose/Condition: _____ (PRN, describe symptoms) _____

Medication Name: _____ Dose: _____

Route: _____ Time/Frequency: _____

PRN frequency: _____

Prescriber's Name/Title: _____

(Use for MD stamp)

Parent Portion: Parents must sign and complete this section.

I permit the school nurse to administer medication to my child during school or at a school-sponsored field trip from **Sept. 2024 to June 2025** as prescribed/ordered by my doctor.

The parents must **bring the medication, give it to the nurse**, and label it appropriately—the physician's name on all prescriptions.

Parent Signature: _____

Date: _____

THIS FORM IS NOT FOR **EPI-PENS OR ASTHMA** MEDICATIONS