FARMINGDALE SCHOOL DISTRICT

49 Academy Street
Farmingdale, NJ 07727
Phone: 732-938-9611 Fax: 732-938-2317

Mrs. Edith Conroy
Superintendent of Schools

Mrs. Kirsten Canuso
Business Administrator

Physician Name ____
Address ____
____
Phone Number ____

MEDICATION PERMISSION FORM

Date ____
Student's Name ____
Diagnosis ____

Medication/Dose ______________________ Administration ______________________
______________________ ______________________
______________________ ______________________

( ) Medication shall be administered in the presence of the School Nurse or designated authority (______________________________) only.
( ) Medication may be self-administered by the student. He or she is capable of, and has been instructed in, the proper method of self-administration of the medication.

Physician's Signature ____

I, ________________________, parent/guardian of ______________________, give permission for my child to receive the above medication(s) from the school nurse or designated authority (________________) for the treatment of ______________.

OR.

I, ________________________, parent/guardian of ______________________, give permission for my child to self-administer the above medication(s) for the treatment of ________________ for which he/she has been trained.

Parent/Guardian Signature ____