

**FARMINGDALE SCHOOL DISTRICT**

**49 Academy Street**

**Farmingdale, NJ 07727**

**Phone: 732-938-9611**

**Fax: 732-938-2317**

**Edith Conroy, Ed.D.  
Superintendent of Schools**

**Mr. Ronald Sanasac  
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 \_\_\_\_\_