SOMERDALE PARK SCHOOL

Mary E. Dow, RN BSN CSN
School Nurse

Health Office
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Somerdale, New Jersey 08083

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***FOR OVER THE COUNTER MEDICATIONS*: PLEASE COMPLETE THE FORM BELOW, SIGN THE PARENT CONSENT AREA AND RETURN TO THE SCHOOL NURSE. NOTE: PLEASE BE SPECIFIC ABOUT PURPOSE OF MEDICATION, ie; Tylenol – you must indicate what to use it for; headaches, cramps, pain, fever etc. If the student presents with a situation other than what you have written for, the school nurse cannot administer the medication without obtaining further consent.**

Student's Name:_____
Grade:_____ Teacher: _____ DOB:_____ Age:_____

Medication: _____ Dosage:_____

Time: _____Frequency:_____

Length of Time Prescribed: _____
(ie: school year-please keep in mind this is valid only for current school year)

Purpose of Medication: _____

Possible Side Effects: _____

PARENT CONSENT:

I request that the school nurse administer the above medication as outlined on an as needed basis during school hours. I understand that the school nurse may refuse to administer any Over The Counter medication at her discretion. ****If any Over The Counter medication is medically necessary then please supply a physician's prescription and follow the prescription medication guidelines.

_____
Parent(s)/Guardian's Signature
Date: _____ Home Phone: _____
Work/Cell Phone: _____