Academies at Gerrard Berman Day School

Medication Consent Form 2016-2017

New Jersey State Law requires the use of a written consent form in order to dispense any medication in school. This includes all over- the- counter medications (Tylenol, Advil/Motrin, decongestant, cough medicines, eye drops, etc.) as well as all prescription medications. This form must be signed by both the parent and the doctor; there can be no exceptions and no telephone (verbal) permission. Under no circumstances will medication be dispensed without proper documentation. This permission form will remain in effect for the entire school year indicated (Sept- June). Any medication sent to school must be in the original container that is appropriately labeled by the pharmacy or manufacturer. A new form must be filled out for each new school year. A new form will be completed if additional medications are requested during the school year.

*** If you want **no** medications available to your child during the school year, write "NONE" across the form, sign and return it to the Nursing Office.

Thank you in advance,
Melissa Ayala, R.N. ext 210

Name of Student__________________________________ Grade__________________

Prescriptions - Daily Administration or As Necessary

Name of Medication_____________________________ Dosage___________________
Reason for administration____
Time of administration________________ Give if early dismissal Yes____ No_______
Possible side effects_______________________________________

Name of Medication_____________________________ Dosage___________________
Reason for administration____
Time of administration________________ Give if early dismissal Yes____ No_______
Possible side effects_______________________________________

Over the counter - As Necessary Medications

Acetaminophen Dosage_________________
Reason for administration____
Ibuprofen Dosage__________________
Reason for administration ____________________ ____________________________
Tums or Pepto-Bismol Circle choice Dosage______________________
Reason for administration ____
Other OTC Medication Dosage______________
Reason for Administration____

I authorize the school nurse to administer the above medications.

****Parent/ Guardian_______________________________________**

****Physician____________________________________ MD STAMP: ______________________**

*****MUST BE SIGNED BEFORE ADMINISTERING ANY MEDICATION*****