PASSAIC COUNTY TECHNICAL INSTITUTE

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MEDICATION DISPENSING FORM

Student's Name _____ I.D. #_____ Age ___Grade ___

Medication Prescription _____

_____

Administration in School _____Home _____

Effective Dates: From _____ To _____

Diagnosis _____

Special Instructions _____

_____

It is my understanding that the School Nurse charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

_____ _____
Doctor's Name (Print) Doctor's Signature

_____ _____
Doctor's Address Doctor's Telephone Number

_____
Patient's Medication Allergies

- **The medication is to be provided by me in the original labeled container. This includes medication prescribed by a physician and all "over the counter" medication, such as Tylenol.**
- **To my knowledge, my child is not allergic to this medication.**
- **I hereby relieve the board and its employees of any and all liability that may result from administration of the medication to my child.**

_____ _____ _____
Parent/Guardian Signature Emergency Phone # Date