Downe Township Elementary School
220 Main Street
Newport, New Jersey 08345
Tel: 856-447-4673 Fax: 856-447-3005

Consent for Administration of Approved Medication – 5th to 8th grade ONLY

Name: _____Date of Birth: _____
Teacher: _____ Grade:_____

Medication Allergies/Sensitivities:

_____

Current Daily Medications:

_____

Medical/Health Problems:

_____

I give permission for my child, to receive any medication checked below on this form deemed necessary by the Registered Nurse/School Nurse. Dosage will be calculated by the dose recommendations already labeled on the medication according to the child's weight and age. I understand that generic equivalent medications may be used. I would like the following medication made available to my child:

For Headache/Burns/Earache/Muscle Aches/Pain/Menstrual Cramps:
_____ Tylenol

I understand that the above medications I have checked will be administered by the Registered Nurse/School Nurse in accordance with established protocols developed by the School Physician and in accordance with Downe Township School Standing Medication Orders.

_____ I do not want any medication given to my child in school.

_____ _____
Parent/Guardian Signature Date