Greenwich Township School District

2016-2017 Other Medication Form

(i.e. pain medication, antibiotics, eye drops and the administration of other short term medication)

To be completed by parent/guardian:

Pupil: ______ **DOB:** ______ **Grade:** ______ **Teacher:** ______

Physician: ______ **Physician Telephone Number:** ______

I, hereby, grant permission for my child to receive medication at school as prescribed by my child's physician. I release the Greenwich Township Board of Education, its officers, employees, agents, and representatives from any and all claims, liability or damages related to or resulting from the administration of medication to my child. I also grant permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and medications.

Parent/Guardian Signature: ______ **Date:** ______

To be completed by physician:

Is this child allergic to medications? ☐ **No** ☐ **Yes, please list** ______.

Diagnosis: ______ **Medication:** ______

Route: ______ **Dosage:** ______ **Time:** ______

Side Effects: ______ **Number of Days:** ______

Medication Order for Day of Class Trip: ☐ Dose may be omitted.

☐ Schedule may be adjusted as follows: ______

Physician Signature: ______ **Date:** ______