Lynn DiPietropolo
Interim Superintendent

Lesa Robbins
School Business Administrator
Board Secretary

Tyler Day
Director of Special Services

Dr. Regina Washington
Principal
Director of Curriculum & Instruction

Dr. Kerri Zeleniak
Assistant Principal

COMMERCIAL TOWNSHIP-MEDICATION CONSENT FORM

Student Name_____DOB_____

Grade/Teacher_____

TO BE COMPLETED BY PHYSICIAN

Diagnosis:_____

Name of Medication to be Administered_____

Dose:_____Time(s) to be given in school_____

If PRN, provide criteria:_____

Length of time prescribed: Start Date_____Stop Date:_____

Precautions/Possible Side Effects:_____

Student needs to take medication while attending field trip (circle): YES NO

Stimulant medication time(s) can be rescheduled to (time)_____on field trips.

Physician's Name (Printed)_____Physician's Signature_____

Address_____Phone #_____

--------TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for the school nurse at Commercial Township School to administer the above medication, as prescribed by my child's physician, to my child_____. I understand that no medication will be given to my child unless it is brought to school in the original container and properly labeled from the pharmacy/manufacturer. I authorize, as needed, the sharing of information related to my child's health between the school and the healthcare provider listed above.

Please administer the above named medication to my child on early dismissal days (check one):Yes____No____

Signature of Parent/Guardian_____Date_____