Gloucester City Board of Education
Gloucester City, NJ

PARENTAL PERMISSION FORM

School Year: _____

I request the enclosed medication, in the original container, to be administered to my child and shall release school personnel from all liability. I give the School Nurse permission to contact the physician and/or pharmacist with any questions concerning the medication.

Student Name: _____ Grade: _____

Name and strength of medication: _____
Dosage and time: _____

Signature of Parent/Guardian: _____

In case of potentially life threatening illness, will the student be giving himself/herself this medication?
Yes____ No____ If yes please sign below

I, the parent/guardian of _____ acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of the medication by the student and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student. The permission is effective for the school year which it is granted.
Signature of parent/guardian: _____

PHYSICIAN'S AUTHORIZATION

Student Name: _____ Grade: _____
Name, dosage, route of medication: _____
Reason for Medication: _____
Effective Dates: From _____ To: _____
Medication Allergies: _____

It is my understanding that the School Nurse charged with the administration of medication may rely upon my directions as contained on the 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 the diagnoses and treatment. Any alteration to the above will occur only with written directions from the attending physician.
Physician: _____ _____
Printed Name Signature
Address: _____
Office telephone: _____ Fax: _____
Date: _____