

Greenwich Township School District

2022-2023 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: _____