Township of Ocean School District
James Stefankiewicz
Superintendent of Schools

Consent Form to Administer Medication

_____ _____
Name of student *School and Grade*

is being treated for _____
Illness

and is to be given _____ at _____
Name of Medication *Time/s*

Dosage _____ for _____
Period of time to be given

Contraindications for administration would be_____
_____
_____

Possible Side Effects _____
_____

_____ _____
Physician's Signature *Date*

Physician's Stamp (required)

I request that the above medication be administered to my child.

_____ _____
Parent/Guardian's Signature *Date*

163 Monmouth Rd., Oakhurst NJ 07755 Phone 732-531-5600 Fax 732-531-3874 www.oceanschools.org