Ocean Township High School

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SPARTAN MISSION:
Meeting the needs of all students with a proud tradition of academic excellence.

MEDICATION FORM

_____is being treated for
Name of Student
_____and is to be given
Illness

_____**at**_____
Name of Medication Time(s)

_____
Dosage Period of Time to be Administered

Contraindications for the administration would be_____

Possible Side Effects_____

_____

_____ _____
Physician's Signature *Date*

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

_____ _____
Parent's Signature *Date*

Medication Drop off:

_____ _____
Parent's Signature **Date**

Medication Pick up:

_____ _____
Parent's Signature ***Date***

Home of the Spartans!
#SpartanLegacy