

## **Township of Ocean Schools**

Office of the Superintendent

## **SPARTAN MISSION:**

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

## **Consent Form to Administer Medication**

Name of student		School	Grade
is being treated for			
<u> </u>	Illness		
and is to be given		at	
and 10 to 20 given	Name of Medication	at 	
Dosage	for		
		Period of time to be given	
Contraindications for	administration would be		
Possible Side Effects			
Physician's Si	gnature	 Date	
-	_		
Physician's Stamp (re	equired)		
I request that the ab	l pove medication be administe	ered to my child.	
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Parent/Guardian's Signature		 Date	

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

