**MOTHER SETON REGIONAL HIGH SCHOOL**
**ONE VALLEY ROAD, CLARK, NJ 07066**

# PARENTAL/PHYSICIAN PERMISSION TO TAKE MEDICATION IN SCHOOL - 2018-2019

**Statement of Parental Permission to take Medication in School**

**STUDENT'S NAME** _____ **GRADE**_____

PLEASE CHECK ONE

1.____ I give permission for my daughter to take appropriate medication as indicated by her physician**. In this case, she must bring this medication to school appropriately labeled**. It will be kept in the Health Office. **This includes Tylenol and/or any other prescription or "over-the-counter" medication.**

2.____ I do not wish my daughter to take any medications in school.

PARENT/GUARDIAN SIGNATURE _____

DATE: _____

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**School Year 2018-2019**

**Statement of Physician's Permission to take Medication in School**

**STUDENT'S NAME** _____ **GRADE** _____

has permission to take medication as indicated below in school. I understand that **she will bring this medication to the Health Office**, store it in that office and take it in the presence of the nurse or her designee.

**The doctor must identify the diagnosis, the medication, the dosage and times for administration. This is in accordance with NJ State law**.

PHYSICIAN'S SIGNATURE _____

ADDRESS: _____PHONE #: _____

DATE: _____

Diagnosis: _____

Tylenol: _____ (Provided by parent)

Advil: _____ (Provided by parent)

Aleve: _____(Provided by parent)

Other: _____(Provided by parent)