LOWER CAPE MAY REGIONAL SCHOOL DISTRICT - MEDICATION ADMINISTRATION RECORD & CONSENT SHEET 2024-2025

I request that (student name): _____ DOB: _____/_____/_____ receives the following medication(s) (circle any permitted):

ANY NEEDED IBUPROFEN/MOTRIN/ADVIL ACETAMINOPHEN/TYLENOL ANTACIDS/TUMS COUGH DROPS OTHER: _____

as needed during the rest of the 2024-2025 school year unless cancelled by the parent/guardian in writing. Medications should be supplied from home in original bottle. All medications MUST be kept in nurse's office. Absolutely no medications will be given without consent from the parent/guardian.

I give consent for medication administration for the 2024-2025 school year as listed above: Parent Signature: _____ Date: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SEPT	_	_					_	_						_	_						_	_						_	_		_
OCT					_	_						_	_						_	_						_	_				
NOV		_	_	_	_	_	_	_	_	_						_	_						_	_				_	_	_	_
DEC	_						_	_						_	_						_	_	_	_	_	_	_	_	_	_	_
JAN	_			_	_						_	_						_	_						_	_					
FEB	_	_						_	_						_	_	_					_	_						_	_	_
MAR	_	_						_	_					_	_	_						_	_						_	_	
APR					_	_						_	_					_	_	_	_	_	_	_	_	_	_				_
MAY			_	_						_	_						_	_							_	_	_				_
JUN	_						_	_						_	_		_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_

NURSE'S SIGNATURE

_____ _____ _____ _____

_____ _____ _____ _____

CODES

A: Absent D: Dismissed Early

X: No Show ---: Weekend/Holiday