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

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

Prescribed by (doctor): _____ for (reason/illness):_____

This medication is to be given (daily, etc.) _____ Administered on early dismissal days? _____

Absolutely NO prescribed medication will be given without parent/guardian signature on this consent sheet.

Prescription medications MUST have a prescription or note from the doctor including medication name, dose, and time to be given.

Medications MUST be in the labeled prescription bottle from the pharmacy and MUST be kept in the nurse's office.

Students must have appropriate paperwork to self-carry inhalers (asthma action plan) or epi pens (epi pen forms)

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

N: None Available ---: Weekend/Holiday