



Burch Charter School of Excellence
100 Linden Avenue, Irvington, NJ 07111
P(973) 373-3223 Fax 973-373-3228

IN SCHOOL MEDICATION CONSENT FORM

Name of Student: _____ Date of Birth: _____ Grade: _____

Medication order is valid only for the current school year _____ .

This form must be completed fully in order for schools to administer the required medication.

A new medication administration form must be completed at the beginning of each school year,

- ***Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- ***Non-prescription medication must be in the original container with the label intact.**
- ***An adult must bring the medication to the school.**

Name of Student: _____ Date of Birth: _____ Grade: _____

Diagnosis for medication _____

Medication Name: _____ Dose: _____ Route: _____

Possible side effect from medication given _____

Medication	Dosage	Time to be given	Start and End Date

Doctor's Name _____ Signature _____ Date _____ Phone # _____

Parent-permission given to the school nurse or school personnel designated to administer this medication Yes No

Parents' Name _____ Signature _____

Phone # _____ Date _____

School Excuses absences will be granted only with Doctor's note for all illness or ongoing medical condition