Rock Brook School 2021-2022
Medication Form

Student Information

Student's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Home Phone: (_____) _____ School District: _____

Mother/Guardian Name: _____

Mother Cell Phone: (_____) _____ Business Phone: (_____) _____

Father/Guardian Name: _____

Father Cell Phone: (_____) _____ Business Phone: (_____) _____

Medical Provider Information

Licensed Medical Provider: _____

Address: _____
Street City State Zip

Medical Office Phone: (_____) _____

Physician Stamp

Medication Information including OTC:

Name of Medication: _____ Diagnosis: _____

Start Date: _____ Treatment to be continued until: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time (s) of Administration:: _____

Specific directions for administration: _____

Significant side effects, contraindications, or adverse reactions: _____

_____

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Medication Information including OTC:

Name of Medication:_____ Diagnosis:_____

Start Date:_____Treatment to be continued until:_____

Route of Administration:_____Dosage: _____

Frequency: _____Time (s) of Administration::_____

Specific directions for administration: _____

Significant side effects, contraindications, or adverse reactions:_____

_____

I request that the medication, named above, be given to my child. The medical provider explained to me the medication, its purpose and possible complications. I hereby acknowledge that Rock Brook School shall incur no liability as a result of any injury arising from the administration of this medication and hereby indemnify and hold harmless the Rock Brook School and its employees or agents from any claims arising out of the administration of this medication.

Required Signatures

Mother/Father/Guardian Signature: _____Date: _____

Medical Provider Signature:_____ Date:_____

Please return to Rock Brook School on or before July 6, 2021.

Rock Brook School, ATT: School Nurse * 109 Orchard Road, Skillman, NJ 08558
Tel: 908-431-9500 * Fax: 908-431-9503
nurse@rock-brook.org