



OGDENSBURG BOROUGH BOARD OF EDUCATION
100 Main Street Ogdensburg, NJ 07439

Dave Astor
Superintendent/Principal

Skye Patete
Vice Principal

Richard Rennie
Business Administrator/Board Secretary



PRESCRIPTION or OVER THE COUNTER MEDICATION
ADMINISTRATION FORM

Physician's Section

Student's Name _____ Grade _____

Has been treated for _____

I request that the School Nurse administer medication prescribed by me, for the period

from _____ to _____
Date Date

Rx: _____

Dosage: _____

This medication may be skipped on a Field Trip: Yes _____ No _____
MD initials

Physician's Signature _____ Date _____

Physician's Stamp

Parent/Guardian Section

I understand and agree that medication to be administered in school must be delivered in the original pharmacy container, by myself or another adult, accompanied by this COMPLETED and SIGNED note. UNDER NO CIRCUMSTANCES MAY MEDICINE BE CARRIED BY A STUDENT, EITHER TO SCHOOL OR HOME.

I give my permission for the School Nurse to administer the above prescribed medication.

Signature: _____ Date: _____