NUTLEY PUBLIC SCHOOLS
Nutley, New Jersey 07110

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by PARENT:

School

Child's Name

Last First Sex Date of Birth

Physician's Name Address Telephone Number ( )_____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/herself as also authorized by me and my physician (see below).

Date Parent/Guardian Signature

Home Phone Emergency Phone

The following is to be completed by the PHYSICIAN:
Diagnosis for which medication is given:

Name of Medicine

Form

Dose

If medicine to be given DAILY, at what time?

If medicine to be given "WHEN NEEDED,"--

describe indications

How soon can it be repeated?

Is child authorized to medicate herself/himself?

List significant side effects:

Length of time this treatment is recommended:

Other information:

Date Physician's Signature

Date

Dear School Nurse:

Please administer to my son/daughter

the following medication at_. as per my physician's orders.

Thank you,

Parent/Guardian