## 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 First Sex Date of Birth Telephone Number Address Physician's Name 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). Parent/Guardian Signature Home Phone **Emergency Phone** Date 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	<u>at</u>	•
as per my physician's orders.		
	Thank you,	
	Parent/Guardian	