NUTLEY PUBLIC SCHOOLS
Nutley, New Jersey 07110

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following sections 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 medication _____
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