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