WANAQUE PUBLIC SCHOOLS

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PHYSICIAN AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

Student's Name:________________________ Date of Birth:___/____/___

Today's Date____/____/____ Diagnosis for which medication is prescribed: ___________________

Medication Name/Generic Name of Drug: __________________________________

Dosage: _________ Method/Route:_________ Time of Administration: __________
Start Date ____/____/____ End Date ____/____/____

Specific Instructions for Medication Administration: ____

If medication is to be administered PRN, describe indications: _________________________________

Relevant Side Effects of Medication ___________________________________ None Expected ( )

How soon can it be repeated? ______________

For PRN (as needed) administration, when should the prescribing physician be notified due to the frequency of administration? ____ _______

MEDICATION INFORMATION/ADJUSTMENTS

If this medication is to be given on a regular basis, please indicate what needs to be done when the student is on a class trip or on early closing days. Teaching staff cannot give medications.

Check one:

___Student will not be taking the medication on the day of the class trip.
___Administer medication upon trip return, providing it is within the normal school day
___Parent will assume responsibility for administering the medication.

Circle one: Administer / Do Not Administer the medication on early closing days.

If this medication is prescribed due to an allergy please state if allergy is:
Inhalation _____________ Ingestion__________ Both __________ Unknown_____________

Medical Doctor Signature ____________________________________ Date ______________
Physician's Name:_____________________________ Phone#:________________________

Parent/Guardian Signature ___________________________________ Date ________________

This permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of the requirements stated in the NJSA 18A:40-12.5