SOUTH PLAINFIELD PUPLIC SCHOOLS

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

To be completed by Parent/Guardian:

Child's
Name _____Birthdate_____Grade_____

Physician_____Telephone_____

I request that my child be assisted in taking the medication described below at school by the school nurse. I relieve the Board of Education and its employees of any liability which may result from administration of this medication to my child. (Medication must be brought to school in the original labeled container by the parent/guardian.)

Parent/Guardian Signature_____Date_____

Home Phone_____Emergency Phone_____

To be completed by Physician:

Diagnosis for which medication is given_____

_____

Medication/Dose/Route/Frequency_____

_____

If given daily, at what time?_____

Give daily medication on field trips Yes___ No___
Give daily medication on half-days Yes___ No___

If given when needed, describe indications_____

_____

How soon can medication be repeated_____

Significant side effects_____

Length of time this treatment is recommended_____

Physician's Signature_____Date_____

Physician's stamp: