PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

MEDICATION AUTHORIZATION

Date: _____

Dear Parent/Guardian:

You have indicated that (Name) _____
(Grade)_____ is in need of medication during school hours.

It is our policy to have written permission. Please have your physician complete this form and return to the school nurse.

1. Pupil's name _____
2. Diagnosis _____
3. Name of medication _____

PLEASE NOTE: In the event that the school nurse is not available, a trained delegate is authorized to administer epinephrine ONLY.

4. Dosage of medication _____
5. Route _____
6. Time to be given _____
7. Special instructions _____
   a) May withhold medication with parent written request: Y N
   b) May withhold medication for field trip with parent written request: Y N
8. Side effects _____
9. Physician signature_____
10. Physician (Please print, type or stamp) _____

_____
Phone #

_____
Fax #

Please submit this information as soon as possible, so that the proper schedule can be maintained. If there is any change during the course of this prescribed medication, please notify the school nurse in writing.

_____ _____
School Nurse Parent Signature

_____ _____
School and phone # Date

SN#5A - 5/13