OLD BRIDGE TOWNSHIP PUBLIC SCHOOLS

MEDICATION AUTHORIZATION

Student's Name: ________________________________ **Date:** ____________

Teacher's Name: ________________________________ **School:** __________

Part I: To be completed by Parent/Guardian

I authorize the school medical personnel to see that my child, _________________,

receives the medication prescribed by ___________________________. *(See below.)*

____ ________________ ______

(Parent's /Guardian's Signature) ***(Date)***

Please list all medications that your child is taking at home:

____

Part II: To be completed by Physician

Diagnosis: ____

____

(Medication) ***(Dosage)*** ***(Route of administration)*** ***(Time/Frequency)***

If PRN, state frequency or indication: _______________________________________

Duration of Treatment: ____

Possible Side Effects and Adverse Reaction: ______________________________

Other Recommendations: ____

____

May this medication be omitted on Field Trips? ____**Yes** ____**No**

May this medication be omitted on Half Days? ____**Yes** ____**No**

______________________________________ _____________ _______________

(Physician's Name/Stamp -- Please print) ***(Phone Number)*** ***(FAX Number)***

____ _____________

(Physician's Signature) ***(Date)***

(03/2009)