THE WARDLAW+HARTRIDGE SCHOOL AUTHORIZATION FOR MEDICATION IN SCHOOL

The following section is to be completed by the **PARENT**: School Year: 20__ - 20__

Child's Name:_____ *Date of birth:*_____ *grade:*_____

I request that my child be assisted in taking the medicine described below at school by authorized persons. The medication prescribed below is needed during school hours for my child to properly function and cannot be given at home. Herbal and dietary supplements are not considered medications and cannot be given in school. All medication must be **brought to school by a parent/guardian**, **in an original unopened labeled pharmacy container**, including for over-the-counter medications also. Please check and note expiration date. At the conclusion of treatment/school year (whichever is first) parent/guardian **must pick up** medication or it will be **discarded** on the last day of school. Changes to regime must be put in writing by prescribing physician. I agree that information may be shared with appropriate school personnel on a need to know basis. Neither the Wardlaw+Hartridge School employees or school nurse, and/or the Educational Services Commission of NJ's employees or nurse shall be responsible for any liability as a result of any injury arising from the authorized administration of medication.

_____ _____ _____

Date PRINT NAME parent/guardian Parent/Guardian Signature

Student s 18 and over must sign form themselves

The following section is to be completed by the **PHYSICIAN**:

Child's name:_____ DOB:_____ Diagnosis:_____

Medication: _____Dosage: _____ Route: _____

If medicine is to be given daily, at what time? _____

If medicine is to be given "when needed," describe indications: _____

How soon can it be repeated? _____

Length of time this treatment is recommended: _____

Print Physician's Name: _____

Signature of physician: _____

Address/telephone number_____

Date: _____

Physician's Stamp