

**PEQUANNOCK TOWNSHIP PUBLIC SCHOOLS
HEALTH OFFICE**

AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS
BY CERTIFIED SCHOOL NURSES

New Jersey law requires a physician's written order and parent/guardian authorization for administration of any medication, prescription or over the counter.
The following prescription/non-prescription medication/s may be administered for the present school year (non-prescription may include, e.g. Tylenol, Advil, Lozenges, cough syrup):

PHYSICIAN'S ORDER

Name of Student _____	Date of Birth _____	
Date of Order _____	Grade _____	
Medication/s & Reason Given _____	Dosage _____	Time/s _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate what if any side effects may occur; and impact above medication may have on this student's school performance.

_____ Physician Signature	_____ Address
_____ Print Physician Name	_____ Phone Number

**AUTHORIZATION OF PARENT/GUARDIAN FOR CERTIFIED SCHOOL NURSE TO
ADMINISTER THE ABOVE MEDICATION/S**

Date _____

I hereby request that the certified school nurse give my child, _____, the medication ordered by her/his physician.

_____ Parent/Guardian Signature	_____ Parent/Guardian Print Name
------------------------------------	-------------------------------------