Mahwah Township Public Schools
Physician's Medication Authorizations for
Prescription and Nonprescription Medication

ONE MEDICATION PER FORM

FOR COMPLETION BY PARENT(S)/GUARDIAN(S)

Student's Full Name_____ School Year_____ Grade_____

I understand that I must supply the school with the equipment/supplies needed to administer the medication.

I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. **Prescription** medication must be labeled by a registered pharmacist.

I understand that medication will only be administered during school hours if necessary for child to attend school.

I understand that medication will not be administered to a student who is physically unfit to attend school or has a contagious disease. Any such student should not be permitted to attend school and may be excluded.

I understand that **the physician** will be called if a question arises about my child's medication.

I understand that medication no longer required must be promptly removed by the parent or legal guardian.

I understand after reasonable efforts to have the parent retrieve the medication that remains in the school at the end of the school year or two weeks after the student stops taking the medication, whichever occurs first, must be destroyed or discarded by the school nurse.

I hereby authorize the medication described below to be administered as directed by my child's physician.

_____ _____

Signature of Parent/Guardian Date

FOR COMPLETION BY PHYSICIAN

Name and strength of Medication_____

Reason for medication_____

Route of administration_____

Dosage of medication_____

Time of day medication is to be given_____

Date medication began_____

Date medication discontinued_____

Side effects_____

_____ _____

Physician's Signature (original signature/NO stamps) Date

Physician's Printed Name_____

Physician's Address_____

Physician's Telephone Number_____

MEDICATION RECORD: ADMINISTRATION-PHYSICIAN'S ORDER

School Year: _____ School: _____

Student. _____ DOB:___/___/___ Teacher: _____ Room: _____

Medication, Route: _____ Physician: _____ Phone: _____

Date, Dose. Time: _____ Physician Address: _____

Date, Dose. Time: _____ Comments: _____

Date, Dose, Time: _____ _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															

INIT.	NAME	INIT.	NAME
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____

CODES

_ : Weekend

H : Holiday

A :Absent

N :None Available

F :Field Trip

D :Early Dismissal

W :Dose Withheld

0 :No Show

(Chart Reason)