WARREN HILLS REGIONAL SCHOOL DISTRICT
Health Offices

Middle School - 908-689-0750 ext. 2020
MS FAX - 908-835-0570

High School - 908-689-3050 ext. 2
HS FAX - 908-835-8511

DO NOT RETURN THIS FORM UNLESS YOUR CHILD IS TO RECEIVE MEDICATION, EPIPEN, OR INHALER AT SCHOOL. All medication orders must be renewed each school year. THIS FORM COVERS THE ENTIRE SCHOOL YEAR.

PARENTAL AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING MEDICINES TO STUDENTS

A. To be completed by the Parent or Guardian:

I request that my child_____in grade_____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication.

Please discuss the following with your doctor:
My child will require medication on half days ____yes ____no
My child will require medication on field trips ____yes ____no

Signature (Parent or Guardian)_____
Telephone Number_____ Date_____

B. To be completed by the Physician:

I request that my patient, as listed below, receive the following medication:

Name of pupil_____ Age_____
Diagnosis_____
Name of medication_____
Prescribed dosage and means of administering_____
_____
Time to be taken during school hours_____
Expected duration of treatment_____
Possible side effects and adverse reactions (if any) _____
_____
Epipen/Inhaler:
____ The above mentioned student will carry and use his/her own inhaler as indicated above.
____ The above mentioned student will carry and use his/her own epipen as indicated above.
____ School nurse will administer inhaler/epipen. ____ Nurse must administer on field trips.
Other recommendations_____
_____

Physician (please print)_____ Phone_____

Signature_____ Date_____