WARREN HILLS REGIONAL SCHOOL DISTRICT
Health Offices

Middle School 908-689-0750 ext. 2020 High School 908-689-3050 ext. 2
MS Fax 908-835-0570 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 FROM COVERS THE CURRENT 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 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 medications on field trips ____yes ____no

Signature (Parent or Guardian)_____
Telephone Number _____ Date_____

B. To be completed by Physician:

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

Name of pupil_____age_____
Diagnosis_____
Name if 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
_____The school nurse will administer Inhaler/epipen _____Nurse must administer on field trips

Other recommendations _____

Physicians (please print) _____ Phone _____

Signature _____ Date _____