

SCHOOL # _____

SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

**AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS
TO BE GIVEN DURING REGULAR SCHOOL HOURS**

Date Given _____ Date Returned _____ Medication Started (1st dose) _____

Student's Name _____ DOB ____ / ____ / ____ Grade _____

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

Diagnosis: _____

Medication to be taken during regular school hours:

Printed Name of Physician: _____ Address: _____

Physician's Signature: _____ Telephone: _____

Fax #: _____

PARENT:

I hereby give my permission for the above prescription to be given to: _____
(Print Student Name)

Parent/Guardian Signature _____ Date _____

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator _____ Date _____

All medications must be brought to the school by a responsible adult in the original container, appropriately labeled by the pharmacy;
All medications must be counted by the school nurse, in the presence of the parent/guardian, and signed for.

All medications will be kept in a locked cabinet in the School Health Office, and administered by the School Nurse at the appropriate time.

School Nurse _____ ☎ 973-321-_____