KINNELON PUBLIC SCHOOLS
KINNELON, NJ 07405

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

STUDENT'S NAME:_____ GRADE_____ DOB_____

PARENT'S NAME_____TELEPHONE: (Home)_____
(Work)_____

I request that my child be allowed to take the medication(s) described below at school to be administered by the school nurse. I shall indemnify and hold harmless the district and its employees or agents for legal fees, costs and any potential damages concerning administration of this medication arising out of any claims brought by the above named child or anyone else.

_____ _____
Parent/ Guardian Date

THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

Diagnosis for which the medication is given:_____

Name of medication_____

Type_____ Dose_____

If medication is to be given daily, at what time?_____

If medication is to be given "when needed", describe indications:_____

_____

How soon can it be repeated? _____

List significant side effects:_____

Length of time this treatment is recommended _____

Other information_____

_____

Other medications the child may be on at home:_____

_____

_____ _____
Physician's Signature Date

_____
Stamp or Type Physician's Name