SCHOOL #_____ **SCHOOL YEAR**_____

PATERSON PUBLIC SCHOOLS

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

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

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

PHYSICIAN:

Please give the above named student the following;

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

Diagnosis: _____

Medication to be taken during school hours: ☐ **YES** ☐ **NO**

Printed Name of Physician: _____ Address: _____

Physician's Signature: _____ Telephone: _____

Fax #: _____

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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 school hours.

School Doctor / Administrator _____ Date _____

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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-_____

Revised 7/08