New Providence Board of Education
356 Elkwood Avenue
New Providence, NJ 07974

Physician Authorization for Medication Administration in School

Student Name: _____ Grade: _____ Date of Birth: _____

Diagnosis for which medication is prescribed: _____

Name of Medication #1: _____

Dose: _____

Route of Administration: ☐ Oral ☐ Inhalation ☐ Other: _____

Timing/frequency: _____

Possible side effects: _____

Name of Medication #2: _____

Dose: _____

Route of Administration: ☐ Oral ☐ Inhalation ☐ Other: _____

Timing/frequency: _____

Possible side effects: _____

Date Prescribed: _____ Discontinue Date:_____

I am the physician of the above-named student. The student is physically fit to attend school and is free of contagious disease. I certify that the student's health and continuing attendance at school require the administration of the above list medication(s) during school hours and including field trips.

Physician Signature: _____

Stamp Physician Name: _____