MORRIS COUNTY SCHOOL OF TECHNOLOGY

Parent Authorization for Medication to be Taken During School Hours

Student's Name _____ **Sex** _____ **Date of Birth** _____

Academy _____ **Grade** _____ **Home Phone** _____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

_____ _____

Parent/Guardian Signature **Date**

_____ _____ _____

Parent/Guardian's Name (please print) **Work #** **Cell #**

Physician Authorization for Medications to be Taken During School Hours

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE/ROUTE: _____

TIMES TO BE ADMINISTERED: _____

If medication is "when needed", describe indications:

_____

_____

HOW SOON CAN DOSAGE BE REPEATED? _____

POSSIBLE SIDE EFFECTS: _____

LENGTH OF TIME MEDICATION IS TO BE CONTINUED: _____

_____ _____

Physician's Signature **Date**

Physician's Stamp (include phone and fax numbers):