MATAWAN ABERDEEN REGIONAL SCHOOL DISTRICT
PHYSICIAN/DENTIST AUTHORIZATION TO ADMINISTER MEDICATION

I certify that it is essential to the health of _____, Grade_____, that the following medication be administered during school hours, as directed.

Medication: _____

Diagnosis: _____

Dosage: _____ Frequency of Administration: _____

Mode and Time of Administration: _____

Side effects: _____

_____ _____

Date Signature of Physician/Dentist Physician Stamp Here

DIASTAT CAN ONLY BE GIVEN IF THE NURSE IS PRESENT.

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PARENT/GUARDIAN MUST COMPLETE THIS SECTION.

I hereby request that the school nurse administer the medication specified above, as directed by my Physician/Dentist, to my child _____. I will supply the medication in the **ORIGINAL CONTAINER** and will promptly notify the School Nurse of any changes to this order.

_____ _____

Date **Parent/Guardian Signature**

I verify that my child has my permission to self-administer the medication as directed above and specified in School Board Policy 5141.21 and 5141.21R, **ONLY with certification from the student's physician acknowledging that the student has been instructed in the proper method of self-administration of the medication. (asthma/anaphylaxis/adrenal insufficiency)**

_____ _____

Date **Parent/Guardian Signature**

Waiver of Liability (waiver MUST be signed by Parent/Guardian for administration of medication by nurse, designee or self-administration by student) I agree that if the procedures specified in School Board Policy 5141.21 and 5141.21R, regarding the administration of medication are followed, the school district and its employees or agents shall incur no liability as a result of any injury.

_____ _____

Date **Parent/Guardian Signature**

MEDICATION RECEIVED

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________

Medication ______________________ **Quantity** __________ **Date** _____________

Parent/Guardian Signature: ______________________ **School Nurse:** ____________