HARRISON TOWNSHIP ELEMENTARY SCHOOL

120 N. Main Street
MULLICA HILL, NEW JERSEY 08062
(856) 478-2016
www.harrisontwp.k12.nj.us

Medication Administration Authorization

Physician: Please read the District Policy (on the reverse) and complete this form.

STUDENT'S NAME ______________________________ D.O.B. ______________

REASON FOR MEDICATION **(Diagnosis)** ______________________________

Known Drug Allergies:______________________________

- **ONLY ONE MEDICATION ORDER PER FORM, PLEASE!**

NAME OF MEDICATION ______________________________

DOSAGE ______________________________ Time to be administered __________

Route of Administration ______________________________

Additional Instructions ______________________________

Precautions/Side Effects ______________________________

Treatment/Action ______________________________

Must this medication be given on early dismissals? ______________________________

Must this medication be given on Field Trips? ______________________________

______________	______________________	______________
Date	Physician's Signature	Telephone

Please print, type or stamp Physician's Name, Telephone Number and Address

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PARENTAL PERMISSION

Medication has been prescribed for my child, ______________________. As Parent/Guardian, I hereby request the administration of the medication prescribed above to my child and release Harrison Twp School District and its employees of any responsibility or liability in giving this medication. **I understand I must bring the medication to school labeled and in the original container.**

Date ______________ Signature of Parent/Guardian ______________________________