



21 Belmont Avenue, Dover, New Jersey 07801

Luis Jaime

Superintendent

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Dear Parent/Guardian:

Attached is the **Dover School District Medication Authorization** form that will need to be completed by yourself and your child's doctor in order for your child to receive prescription or over-the-counter medication during the school day.

All medication must be brought in to your child's school nurse by the parent/guardian in the original labeled container from the pharmacy. Many pharmacies will provide you with an extra bottle properly labeled for school. Medications **may not** be sent into school in your child's backpack.

This authorization form is good for one school year; a new form will need to be completed each school year.

All unused medications must be picked up at the end of the school year by the parent/guardian. Any unused medication that remains in the school at the end of the school year will be discarded.

Thank you.



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Estimado Padre/Tutor:

Adjunto se encuentra el formulario de **Autorización de Medicamentos del Distrito Escolar de Dover** que deberá ser completado por usted y el médico de su hijo(a) para que su hijo(a) reciba medicamentos recetados o de venta libre durante el día escolar.

Todos los medicamentos deben ser llevados a la enfermera de la escuela de su hijo(a) por el padre/tutor en el envase original etiquetado de la farmacia. Muchas farmacias le proporcionarán un envase adicional debidamente etiquetado para la escuela. Los medicamentos **no pueden** ser enviados a la escuela en la mochila de su hijo(a).

Este formulario de autorización es válido durante un (1) año escolar; deberá completar un nuevo formulario cada año escolar.

Todos los medicamentos no utilizados deben ser recogidos al final del año escolar por el padre/tutor. Cualquier medicamento no utilizado que permanezca en la escuela al final del año escolar será desechado.

Gracias.

DOVER SCHOOL DISTRICT

MEDICATION AUTHORIZATION

TO BE COMPLETED BY PARENT OR GUARDIAN: (please print)

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

School _____ Grade _____ Height (inches) _____ Weight (lbs.) _____

Primary Care Provider Name (MD, DO, PA, APN) Telephone Number _____

I request that my child be given the following medication described below at school by the school nurse.

Parent/Guardian Signature _____

Date _____

Telephone Number _____

TO BE COMPLETED BY THE STUDENT'S PRIMARY HEALTH CARE PROVIDER: (please print)

Diagnosis for which medicine is to be given: _____

Name of Medication: _____

Dosage: _____ Form (tablet, liquid) _____ Frequency: _____

If medication is given **daily**, what Time: _____

If medicine is given "**PRN**" please specify: _____

Limitations: _____ How soon can it be repeated: _____

List significant side effects: _____

Length of time medication is recommended: _____

Other information: _____

Primary Care Provider Signature _____

Date _____

Official Stamp _____