Saddle River Day School

Medication Administration Authorization Form

September 2025-June 2026

Student: ____ **Grade**: _____ **Date of Birth**:__________________

Allergies: ____

Students are prohibited from self-medicating in school. The decision to administer over-the-counter (OTC) medications will be based on the School Nurse's assessment and requires **written consent** from the student's parent/guardian and health care provider.

A student with life-threatening illness may self-medicate with an inhaler or epinephrine injector if the proper consent forms are completed and signed by their medical provider and their parent/guardian.

"As needed" medications may be administered by the School Nurse only when the student's parent/guardian and health care provider complete and sign this authorization form listing specific medication, purpose, dosing, route, times when such medication can be given, and termination date. If there is no termination date listed, this authorization will remain in effect until the last day of the current school year.

Any prescription or over-the-counter medication brought to school must be specific to the student who is to receive the medication, in its original container, have a child-resistant safety cap, and be labeled with the information as follows:

- Prescription medication must have the original pharmacist label that includes the pharmacists phone number, the student's name, name of the health care provider prescribing the medication, name and expiration date of the medication, dosage, route, frequency, and any special instructions for its administration and/or storage.
- OTC medication must have the student's full name on the container, and the manufacturer's original label with dosage, route, frequency, and any special instructions for administration and storage, and expiration date must be clearly visible.
- Any OTC without instructions for administration specific to the age of the student receiving the medication must have a completed authorization form from the health care provider and parent/guardian prior to being given (i.e. Eye Drops for allergies).

Part I: Parental Authorization

I give permission for my child to be medicated by the School Nurse according to my child's physician's instructions. I will notify the school immediately if my child's health status changes or there is a cancellation or change in the medication. To my knowledge, my child is not allergic to the medication identified on this form.

I understand that all prescription medication must be brought to school by a parent/guardian in the original pharmacy container with label. Over-the-counter medicine must be in the original container. No medication will be given without the written permission of the health care provider and the parent/guardian. I understand that medication must be picked up by an adult by the last day of the school year or it will be discarded.

I hereby release Saddle River Day School and its employees, agents, and trustees of any and all liability in any way related to or which may result from administration to my child of the medication identified below.

Parent/Guardian Signature: ____________________________________ Date: ______________________

PLEASE have your student's medical provider complete page 2 of this form.

Part II: Physician Authorization

Over the Counter Medication:

To the physician: please initial all medications/orders you would like the above student to receive at school.

Initial	Medication	Dose (specify liquid or tablet if needed)
	Ibuprofen (Advil/Motrin)	
	Acetaminophen (Tylenol)	
	Diphenhydramine (Benadryl)	
	Zyrtec	
	Tums	2 tablets by mouth for upset stomach
	Pepto Bismol	2 tablets by mouth for nausea/upset stomach
	Hydrocortisone 1% cream	Topical for itching/rash
	Cough Drops (5th Grade and up ONLY)	1 lozenge as needed for cough/sore throat

Prescription/Other Medication:

Medication	
Reason	
Dose	
Route	
Time	
Possible side effects	

Medication	
Reason	
Dose	
Route	
Time	
Possible side effects	

The physician must complete this for ANY medication, including over-the-counter medications. Students with asthma/allergies/other health concerns requiring rescue medications must have a written action/health plan in place completed by their physician and submitted to the school nurse.

Office Stamp:	Physician's Signature: Physician's Name: Date: