

SOUTHAMPTON TOWNSHIP SCHOOLS

in Historic Vincentown Village

100 Miss Mabel Drive

Southampton, New Jersey 08088

Telephone (609) 859-2256 ext.143 Facsimile (609) 859-3048

“Building a Tradition of Excellence”

MEDICATION AUTHORIZATION FORM

School Year: _____ **School #** _____

Physician's Order:

Name of Child: _____

Name of Medication: _____

Dosage: _____

Time/Frequency: _____

Reason for Medication: _____

Possible Side Effects: _____

Estimated Termination Date: _____

(All authorizations expire at the end of the current school year.)

Physician's Instructions for Class Trips (when school nurse or parent not present):

_____ Medication may be omitted when the child is on a class trip.

_____ Dosage schedule may be altered as follows: _____

_____ Child is knowledgeable about this medication and how to administer it, and may self-administer medication on class trips (with teacher supervision).

Physician's Signature: _____ Date: _____

Physician's Address: _____

Physician's Telephone Number: _____

I request this medication be given to my child, _____, as prescribed by my child's physician.

_____ My child may self-administer his/her medication on class trips.

Date: _____ Parent/Guardian Signature: _____