Authorization and Consent to Administer Medication

Sayreville School District

P.O. Box 997
Sayreville, NJ 08871

Student's Name:_____ DOB:_____ Grade:_____

Address:_____ Teacher:_____

Telephone:_____ Cell Phone:_____

I (we) request authorization and consent to have the school nurse or an appointed faculty member administer medication as prescribed by our private physician to my child while in school. I (we) also hereby release the board of education, the school physician, school nurse and all of their employees from any liability connected therewith.

Date:_____ Parent/Guardian Signature:_____

Parent/Guardian Signature:_____

Name of Student:_____

Name of Medication:_____

Circumstances for the administration of the medication?_____

Prescribed dosage:_____ Route of Administration:_____

Specific time of administration:_____

How long do you expect this student to be on the medication?_____

Side effects that may be expected:_____

Comments or suggestions:_____

Physician's Signature:_____

Health Office/Physician Stamp