Schoenly School Health Office
80 Kane Avenue
Spotswood, NJ 08884
732-723-2200 extension 4040
732-723-2285 – FAX

The parent/guardian of: Name of Child: _____DOB: _____
ask that the school nurse give their child the following medication(s) during school hours:

Name of medication, dosage, and time(s): _____
according to the Health Care Provider's signed instructions on the lower part of this form.

1. It is the parent/guardian's responsibility to furnish the medication.
2. The medication must be handed to the nurse and never placed in a child's backpack.
3. The parent agrees to pick up expired or unused medication within one week of notification by the nurse.
4. Prescription medications must come in the original container labeled with: child's name, name of medication. Pharmacy name and phone number must also be included on the label.
5. Over the counter medications must be in the original packaging.
6. Dosage must match the signed health care provider authorization.

By signing this document, I understand the instructions above and I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

Parent/Legal Guardian's Name: _____Date: _____

Parent/Legal Guardian Signature: _____

Please ask the pharmacist for a separate medicine bottle to keep at school.
Thank you!
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Health Care Provider Authorization to Administer Medication in School

Child's Name: _____ Birthdate: _____

Medication: (one per sheet)

_____

Dosage: _____ Route: _____ Time(s) of administration: _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Start Date: _____ End Date: _____

Signature of Health Care Provider with Prescriptive Authority: _____

License Number: _____ STAMP HERE:

Revised 1/2020