MORRIS COUNTY SCHOOL OF TECHNOLOGY

Parent Authorization for Medication to be Taken During School Hours

Student's Name _____ **Date of Birth** _____

Academy _____ **Grade** _____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Parent/Guardian's Name (please print) **Phone #**

Physician Authorization for Medications to be Taken During School Hours

***DIAGNOSIS* (*please check*):**

☐ **HEADACHE** ☐ **FEVER** ☐ **MENSES** ☐ **OTHER:** _____

***MEDICATION* (please check):**

☐ **IBUPROFEN (ADVIL) 400MG PO PRN EVERY 6 HOURS AS NEEDED**

☐ **ACETAMINOPHEN 650mg PO PRN EVERY 4 HOURS AS NEEDED**

WHEN NEEDED (PRN) INDICATIONS:

-Mild to moderate pain due to headache.

-Fever greater than 100 degrees Fahrenheit.

-Pain due to dysmenorrhea.

POSSIBLE SIDE EFFECTS: Increase Headache, dizziness, drowsiness, fatigue, tremors, confusion, insomnia, anxiety, depression, nausea, vomiting, abdominal pain.

LENGTH OF TIME MEDICATION IS TO BE CONTINUED: School year_____

_____ _____
Physician's Signature **Date**
Must be dated after 7/1 for current school year.

Physician's Stamp (include phone and fax numbers):