



Manville School District

Dorothy Eason • Special Services Department • 908.231.8500 x8536
1600 Brooks Blvd., Manville, NJ 08835 • www.manvilleschools.org

HEALTHCARE PROVIDER AUTHORIZATION FOR MEDICATION

(Authorization valid for current school year)

Student: _____

DOB: _____

It is necessary for this child to receive the following medication during school hours:

Medication: _____

Administration Start Date: _____

Discontinue Date: _____

Dose & Route: _____ **Administration Time:** ____/____/____

Diagnosis: _____

Adverse Reactions that may occur: _____

CLASS TRIPS: When a parent/guardian is unable to attend a class trip (please check one):

____ The dose can be withheld on the day of the class trip

____ The time of administration can be adjusted with the parent/guardian

Healthcare Provider Signature

____/____/____
Date

Healthcare Provider Printed Name

OFFICE STAMP

Office Address and Phone Number

Provider: Please complete this section. Signature, Address, Date, and Stamp are required.

-Parent/Guardian: Please read, sign, & date, must be completed prior to administration of medication.

() YES, I want medication to be given on early dismissal (half) days.

() No, I do not want my child to be given medication on an early dismissal (half) day.

I give permission to the school nurse or designee to administer medication to my child as prescribed above. I also give permission for the exchange of information between the school nurse and my child's healthcare provider concerning my child's health and treatment. I understand it is my responsibility to provide the school nurse with written orders from the prescribing healthcare provider for the administration of medication, and to provide the medication and/or replacement as necessary. I will indemnify and hold harmless the Board, its employees and agents against any claim arising out the administration of the above prescribed medication.

Parent/Guardian Signature

____/____/____
Date

Every Child, Every Day



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Medication Inventory

Name of Student:

Date	Medication	Dose	Quantity	Parent/Guardian / RN Signature
RETURN Date				

Every Child, Every Day