



MEDICATION ADMINISTRATION AUTHORIZATION FORM

September 2026 - June 2027

This form is to be completed by both the parent and the child's physician

STUDENT'S NAME: _____

DATE OF BIRTH: _____

WEIGHT: _____

GRADE: _____

GENDER: ☐ Male ☐ Female

Any medication brought to school must be specific to the student who is to receive the medication, in its original container, and be labeled with the information as follows:

- Prescription medication must have the original pharmacist label that includes the pharmacist's phone number, the student's name, name of the health care provider prescribing the medication, name and expiration date of the medication, dosage, route, frequency, and any special instructions for its administration and/or storage.
- OTC medication must have the student's full name on the container, and the manufacturer's original label with dosage, route, frequency, and any special instructions for administration and storage, and expiration date must be clearly visible.
- The expiration date must be current to be administered.

No medication will be given without the written permission of the health care provider and the parent/guardian.

Over-the-Counter Medications

Permission is granted for Saddle River Day School to administer the following OTC medications:

Tylenol (or other Acetaminophen product)	☐ YES ☐ NO
Advil, Motrin (or other Ibuprofen product)	☐ YES ☐ NO
Benadryl (or other Diphenhydramine product)	☐ YES ☐ NO
Zyrtec (or other Cetirizine product)	☐ YES ☐ NO
Tums (or other Calcium Carbonate product)	☐ YES ☐ NO
Pepto Bismol (or other bismuth subsalicylate) *only for 12 years and older*	☐ YES ☐ NO
Hydrocortisone 1% topical cream	☐ YES ☐ NO

Please list any additional OTC medications you would like to grant permission for:

OTC medications will be administered per package instructions unless specified here:

Prescription Medications

Name of Medication: _____

Reason for Medication: _____

Dosage and Route Instructions: _____

If medicine is to be given DAILY, at what time? _____

If medicine is to be given WHEN NEEDED, describe indications: _____

PHYSICIAN NAME: _____ OFFICE #: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN SIGNATURE: _____ Date: _____

PARENTAL CONSENT

I give permission for my child to be medicated by the School Nurse according to my child's physician's instructions. I will notify the school immediately if my child's health status changes or there is a cancellation or change in the medication. To my knowledge, my child is not allergic to the medications identified on this form. I understand that all prescription medication must be brought to school by a parent/guardian in the original pharmacy container with label. Over-the-counter medicine must be in the original container. No medication will be given without the written permission of the health care provider and the parent/guardian. I understand that medication must be picked up by an adult by the last day of the school year or it will be discarded. I hereby release Saddle River Day School and its employees, agents, and trustees of any and all liability in any way related to or which may result from administration to my child of the medication(s) identified above.

PARENT NAME (Print): _____ PHONE #: _____

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____