

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

MEDICATION AUTHORIZATION

Date _____

Dear Parent/Guardian:

You have indicated that (Name) _____

(Grade) _____ is in need of medication during school hours.

It is our policy to have written permission. Please have your physician complete and return to the school nurse.

1. Pupil's name _____

2. Diagnosis _____

3. Name of medication _____

PLEASE NOTE: An order for epinephrine may be administered by a non-medical trained delegate who is authorized to administer epinephrine ONLY. As such, antihistamines or other medications cannot be given by the delegate. Please take this into consideration when writing your order. If you have any questions in this regard, please call the school nurse listed below. Thank you.

4. Dosage of medication _____

5. Route _____

6. Time to be given _____

7. Special instructions _____

8. Side effects _____

9. Signature of physician _____

10. Physician (Please print, type or stamp) _____

Fax No. _____

Date _____

Please submit this information as soon as possible, so that the proper schedule can be maintained. If there is any change during the course of this prescribed medication, please notify the school nurse in writing.

Very truly yours,

School Nurse

Parent's Signature

School _____

Date

Phone No. _____