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 _____

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):**

Physician's Name: _____

Address: _____

Telephone: _____

License No: _____

Fax No. _____

11. 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. _____