AUTHORIZATION FOR PRESCRIPTION MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

Student Name: _____ Date of birth: _____ Grade: _____
Parent/Guardian Name: _____
Home Address: _____
Parent/Guardian Phone: Home: _____ Cell: _____ Work: _____

This section for completion by Licensed Medical Provider: (STAMP)

LMP Name: _____
Address: _____
Phone: _____

Diagnosis for which medication is prescribed: _____
Name of medication: _____ Route: _____ Dosage: _____
Form: _____ Frequency: _____ Time(s): _____
If PRN, for signs & symptoms: _____
Significant side effects and/or contraindications: _____
Start date: _____ Discontinue date: _____
Is child authorized to self-medicate her/himself? Yes_____ No_____

A pupil is only permitted to self-administer medication for asthma or other potentially life-threatening illnesses. Every pupil that is authorized to use self-administered asthma medication MUST have their MDI accessible during the school day and have an Asthma Treatment Plan prepared by the pupil's LMP which shall identify, at a minimum, asthma triggers, the treatment plan and other such elements as required by the Department of Education (N.J.A.C. 6A:16-2.3(b). Students with medication orders for anaphylaxis must have an Allergy Action Plan completed by their LMP and epinephrine auto-injectors submitted to Health Office.

Provider's Signature: _____ Date: _____

This section for completion by Parent/Guardian:
I request that the above medication be administered to my child. I understand and assume the responsibilities as required.
Parent/Guardian Signature: _____ Date: _____

Please Note This completed form, along with the medication, must be hand delivered to the school nurse by the parent/guardian. The medication must be in the original container appropriately labeled by the pharmacy or medical provider.

Every Student Every Day!