

NEWARK CITY SCHOOL DISTRICT

Authorization for the Administration of Medication by School Personnel

Student Name

Date of Birth

Student Address

School

Grade

Teacher

PARENT/GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. Both the parent (top section) and the licensed prescriber (bottom section) must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication.) The prescription label must match the instructions from the prescriber. If it is a non-prescription medication, it must be in the original container.
3. New forms must be submitted each school year and for each new medication. New forms must be submitted when any changes in the original form occur (for example, changes in the dose, time, etc.)

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Signature of parent/guardian

Date

LICENSED PRESCRIBER SECTION

I verify that this medication must be taken by: _____

Name of Student

Diagnosis for which medication is prescribed

Medication

Strength

Dose

Time medication is to be taken

Administration start date

Expiration date

Instructions or precautions, including possible side effects:

Licensed prescriber signature

Date

Licensed prescriber printed name

Phone