## SCHOOL NURSE AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION AND OTC MEDICATION

## RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

## The following section is to be completed by the PARENT/GUARDIAN:

Student's Name	DOB	Grade
individuals authorized to adminis ultimate responsibility for adminis and others may require their pre- school district, agents and its em administration or lack of administ	ter medication to students in stration of the medication is sence at another location at ployees shall incur no liabili tration of the medication pre	escribed below at school by the School Nurse or other in school pursuant to N.J.A.C:.6A:16-2.3. I understand the mine, and I am fully aware that the duties of the school nurse the time that the medication is needed. I understand that the ty as a result of any condition or injury arising from the scribed on this form. I indemnify and hold harmless the arising out of administration or lack of administration of this
Parent/Guardian Signature	Telephone	Date
The following section is t	o be completed by the	e Medical Provider:
Name of medication:		Indication
Dosage:	Route:	Administration Time:
If medicine is be given "PRN", de	escribe indications:	
When can the "PRN" medicine b	e repeated?	
The prescribed	DPRIATE OPTION WHEN A dose can be withheld on the given can be adjusted with t	
Physician's Name	Signature	Date
Office Stamp:		

This form must be individually completed for <u>all medications</u>.

Medications are to be brought to school by the parent in the original container, labeled appropriately by the pharmacy or in the original box if an OTC medication.

All medications will be kept in a locked storage area.

.

It may not be possible to administer daily medication on half session days, early dismissal days or delayed opening days at the prescribed time. Parent/guardian will be notified if the medication could not be given to the student. v042012