HAWORTH PUBLIC SCHOOL
205 Valley Road, Haworth, N.J. 07641
Phone: (201) 384-5526 / Fax: (201) 384-8619

ADMINISTRATION OF MEDICATION IN SCHOOL
Physician Prescription

Date: ____________________ Student's Name/Homeroom: ________________________________

D.O.B.:___________________ Weight: _____________ School Year: ___________________

Medication: ____

Dose: ____

Route: ____

Time: ____

Diagnosis/Reason for Medication: ____

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Possible Side Effects/Effects of Learning: ____

____

Any circumstances when medication should not be given: ____

____

Physician's Signature: ____

Physician's Name: ____
Address: ____
Phone: ____

The physician must complete this for ANY medication, including "over-the-counter" medications.

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PARENTAL AUTHORIZATION

I give permission for my child to be medicated by the school nurse according to my physician's instructions. I will notify the school immediately if my child's health status changes or there is a change or cancellation of the medication. The medication is to be provided by me in the original labeled container. To my knowledge, my child is not allergic to this medication. I hereby relieve the Board and its employees of any and all liability which may result from administration of the medication to my child.

____ ____________________
Parent Signature Date

mydocs/medical form 1.doc

Nancy Polifroni Thursday, September 17, 2015 3:38:01 PM Eastern Daylight Time