Little Ferry Public Schools
Little Ferry, New Jersey 07643

ADMINISTRATION OF MEDICATION IN SCHOOL
Physician Prescription

Date: _____ School: _____

Name: _____
DOB: _____
Weight: _____

Medication: _____
Dose: _____
Route: _____
Time: _____
Diagnosis/Reason for Medication: _____
_____

Possible Side Effect/Effect of Learning: _____
Any circumstances when medication should not be given: _____

Physician's Signature: _____

Physician's Name: _____
Address: _____ City: _____
Phone: _____

PARENT 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.

_____ _____
Parent Signature **Date**

SCHOOL PHYSICIAN AUTHORIZATION

I have reviewed the prescription and approve of it as written.

_____ _____
Physician Signature **Date**

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98/jm