MEDICATIONS TO BE ADMINISTERED AT SCHOOL
BYRAM TOWNSHIP SCHOOLS
MEDICATION AUTHORIZATION FORM

DATE____________________ SCHOOL_____________________

To be completed by PARENT/GUARDIAN:
I give permission for (name of student)______________________Grade_____________
to receive medication at school according to standard school policy. I understand that the medication must be delivered to the nurse in the original pharmacy container, with the student's name on it. I understand coaches and advisors cannot give medications. I will contact the nurse if there is a change in the medication or dosage.

__________________________ _________________________ __________________
Date Parent/Guardian Signature Home Phone

To be completed by PHYSICIAN:

1. Diagnosis for which medication is prescribed___________________________________
2. Name of medication____
3. Dosage__________tablet/capsule_________liquid_________inhaler_____other_____
4. Time to be administered by school nurse_____________________________________
5. Time and dosage when medication is given at home____________________________
6. Describe indication for "PRN" medication is to be given________________________
7. How soon can the medication be repeated_____________________________________
8. Restrictions and/or important side effects: NONE ANTICIPATED______YES_____
   ____
9. How long has the student been taking this medication___________________________
10. Other information/comments____

_________________________ ________________________
Physician's Signature Date

_________________________ ________________________
Physician's Stamp Phone

Please Note

A separate **"Medications To Be Administered At School"** form is required for each individual medication.