MEDFORD TOWNSHIP PUBLIC SCHOOLS
Department of Pupil Personnel Services

MEDICATION AUTHORIZATION

Student's Name: _____

Reason for medication: _____

Medication: _____ Dose: _____ Time: _____

Other times of the day this medication is given: _____

Dose: _____

If the morning dose is missed at home, may it be given in school at the parent's request? Yes ☐ No ☐

Expiration Date: _____ Side Effects: _____

This student is under my medical care, and requires medication during school hours.

The school nurse will dispense all medications.

_____ _____
Doctor's Signature *Date*

Office Stamp:

As the parent/legal guardian of the student listed above, I authorize the school nurse to administer this medication during school hours as prescribed. I understand that all medication must be brought to school with the written prescription on the container. Over the counter drugs must be sent in their original container. No medication will be given without the written permission of the physician and the parent or legal guardian. Permission must be renewed each school year.

_____ _____
Parent/Guardian's Signature *Date*