Closter Public School's Medication Authorization Form

School Year: _____ School: _____

Physician's Order

Student: _____ DOB: _____

Medication: _____ Dosage: _____

Time: _____ Frequency: _____
(if a PRN Medication please indicate the frequency with which it can be repeated)

Reason for Medication: _____

Possible Side Effects: _____

Date medication is to be discontinued: _____

Physician Comments (if needed): _____

[redacted]

Date: _____
Physician's Signature

Please Stamp

_____
Address

_____
Telephone

[redacted]

I request that my son/daughter _____, be administered the Medication prescribed above by the school nurse.

Date: _____ Signature: _____
Parent/Guardian