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): ______________________________________

____

Date: ____

Physician's Signature

Please Stamp

____
Address

____
Telephone

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

Date: ____________________ Signature: ________________________
Parent/Guardian