SADDLE BROOK SCHOOL DISTRICT

355 MAYHILL STREET
SADDLE BROOK, NEW JERSEY 07663

Telephone 201-843-1142
Fax 201-843-0216

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

To be completed by Parent/Guardian:

Child's Name: _____ DOB:_____ Grade:_____

Physician's Name: _____ Phone Number: _____

I request that my child be assisted in taking the medicine described below at school by the school nurse. I relieve the Board of Education and its employees of any liability which may result from administration of this medication to my child. (Medication must be brought to school in the original labeled container.)

Parent/Guardian Signature:_____ Date:_____

Phone Number:_____ Emergency Phone #:_____

To be completed by <u>Physician</u>:

Diagnosis for which medication is given: _____

Medication/Dose/Route/Frequency: _____

_____

If given daily, at what time? _____ Give on field trips: Yes____ No_____

Give on half-days: Yes____ No_____

If given when needed, describe indications: _____

How soon can it be repeated? _____

Significant side effects: _____

Length of time this treatment is recommended: _____

Physician's Signature: _____ Date: _____

Name of Office & Address: _____