River Edge Elementary Schools

ADMINISTRATION OF MEDICATION IN SCHOOL

PHYSICIAN PRESCRIPTION

Date__________ Student Name: ______________________________________DOB____________

Medication:____

Dose: ____

Route: ____

Time: ____

Diagnosis/Reason for Medication:____

____

Possible Side Effects: ____

____

Any circumstances when medication should not be given: __________________________

____

Permission for student to self- medicate? ________

Physician's Signature____

Name/address/ phone/ or office stamp:

PARENT AUTHORIZATION

I give permission for my child to be medicated by the school nurse according to my physician's instructions. I will notify the school immediately if my child's health status changes or if there is a change or cancellation of the medication.

____ ____________________

Parent Signature Date

School Nurse Office numbers:

			Fax:
Cherry Hill School	201 261-3405	ext 2	201 986-1256
Roosevelt School	201 261-1546	ext 2	201 261-0798
New Bridge Center	201 261-5620	ext 2	201 261-1052