SAINT JAMES ELEMENTARY SCHOOL
30 PETERS PLACE
RED BANK, NEW JERSEY 07701

AUTHORIZATION FOR MEDICATION ADMINISTERED AT SCHOOL

(One Medication per page)

STUDENT NAME: _____ DOB: _____ HR: _____ DATE:_____

DIAGNOSIS: _____

MEDICATION & FORM: _____

ROUTE: _____

WHEN: _____

(e.g., every four hours as needed, daily at 12pm, as needed may repeat in 5 min as needed etc.)

REASON(s): _____

(e.g., shortness of breath, pain, wheezing etc)

LENGTH OF TREATMENT: _____

(e.g., school year Sept to June, for 4 days etc)

SIGNIFICANT SIDE EFFECTS: _____

_____/_____/_____

Print MD Name Signature of MD Date

MD STAMP:

I hereby authorize the School Nurse to administer the above listed medication as ordered above.
I also hereby authorize the St. James Elementary staff to carry and administer the medication listed above as ordered by the physician on school trips and field day unless initialed no. No, I do not authorize _____(Initial if NO).

_____/_____/_____

Print Name of Parent/Guardian Signature of Parent/Guardian Date

MD STAMP: _____