TEANECK PUBLIC SCHOOLS
School Health Services
(Authorization for administration of medication during school hours)

Dear Parent/Guardian:

If your child requires medication that must be given during the school hours, sections I and II of this form must be completed and returned to the nurse.

Student's name: _____ DOB: _____ Grade/Classroom #: _____

I. TO BE COMPLETED BY HEALTH CARE PROVIDER:

Diagnosis: _____

Medication: _____ Dosage: _____ Route: _____

Time of **daily** medication: _____

Time/Indication(s) for **PRN** medication: _____

_____

Start Date: _____ End Date: _____

Health Care Provider's Signature: _____

Date: _____

STAMP

II. TO BE COMPLETED BY PARENT/GUARDIAN:

I request that the above medication be given to my child, named above. I release the nurse, school physician, and the Teaneck Board of Education of all responsibility should any untoward reaction occur as a result of my child being administered the above medication. I also authorize the Teaneck Public Schools to obtain relevant information from the above physician as it relates to the administration of the medication that has been prescribed.

Parent/Guardian signature: _____ Date: _____