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: ________________

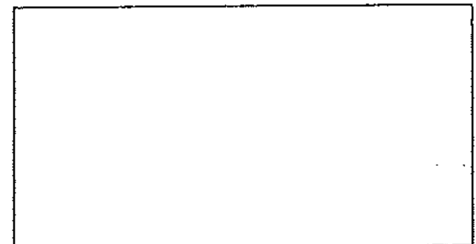
Time/Indication(s) for PRN medication: ____

____

Start Date: __________ End Date: ___________

Health Care Provider's
Signature: ___________________________

Date: ___________________________



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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: _______________