

# Wyckoff Public Schools

## Authorization for Medication To Be Taken During School

The following section is to be completed by the parent/guardian:

Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone#: \_\_\_\_\_

School: \_\_\_\_\_ Grade/Homeroom: \_\_\_\_\_

I hereby grant permission for the school nurse to administer medication to my child as prescribed below for the school year 2008-2009.

\_\_\_\_\_

Date

\_\_\_\_\_

Parent/Guardian's Signature

The following section is to be completed by the physician:

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

If medication is to be taken "**daily**", at what time? \_\_\_\_\_

If medication is to be taken "**when needed**" describe indications:

\_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_

List significant side effects: \_\_\_\_\_

\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_

**Physician's Stamp**

\_\_\_\_\_

Physician Signature

Date