The Academy of Our Lady of Peace
99 South Street
New Providence, NJ 07974

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

(Confidential upon Completion)

NAME OF STUDENT: ___________________________________ GRADE: ________________________

DIAGNOSIS/ILLNESS: ____

MEDICATION: ____

DOSAGE: ___________________________________ FREQUENCY: _____________________________

SPECIAL DIRECTIONS: ____

POSSIBLE SIDE EFFECTS: ____

I CERTIFY THAT THE ABOVE INFORMATION REGARDING THIS STUDENT IS CORRECT, AND THAT ADMINISTRATION OF THE MEDIATION TO THIS STUDENT IS NECESSARY.

____ ________________________

SIGNATURE OF PRESCRIBING PHYSICIAN DATE

____ ________________________

ADDRESS OF PHYSICIAN PHONE NUMBER

I/ WE AUTHORIZE THE SCHOOL NURSE, THE PRINCIPAL, OR THE PRINCIPAL'S DESIGNEE, TO ADMINISTER THE ABOVE MEDICATION AS INDICATED. I/WE UNDERSTAND AND AGREE THAT THE SCHOOL NURSE, THE PRINCIPAL, OR THE PRINCIPAL'S DESIGNEE, SHALL NOT BE LIABLE FOR ANY INJURY TO THE STUDENT FROM THE ADMINISTRATION OF THE MEDICATION AS AUTHORIZED BY MY SIGNATURE BELOW.

__________________________________ ________________________

Signature of Parent /Guardian Date

____

Name of Parent /Guardian (PRINT)

* One form must be completed for each medication to be administered at school, including Tylenol.

Please return to the Health Office

The Academy of Our Lady of Peace
99 South Street
New Providence, NJ 07974

AUTHORIZATION TO SELF-ADMINISTER MEDICATION IN SCHOOL

(To Be Kept Confidential upon Completion)

NAME OF STUDENT: ____________________________________ GRADE: _________________________

DIAGNOSIS/ILLNESS: ____

MEDICATION: ____

DOSAGE: _____________________________________ FREQUENCY: ______________________________

SPECIAL DIRECTIONS: ____

POSSIBLE SIDE EFFECTS: ____

I CERTIFY THAT THE ABOVE INFORMATION REGARDING THIS STUDENT IS CORRECT, AND THAT ADMINISTRATION OF THE MEDIATION TO THIS STUDENT IS NECESSARY, AND THAT THE STUDENT HAS RECEIVED APPROPRIATE INSTRUCTION TO SELF-ADMINISTER THE MEDICATION.

____ ________________________
SIGNATURE OF PRESCRIBING PHYSICIAN DATE

____ ________________________
ADDRESS OF PHYSICIAN PHONE NUMBER

I/ WE AUTHORIZE THE SCHOOL NURSE AND THE PRINCIPAL TO PERMIT THE STUDENT TO SELF-ADMINISTER THE ABOVE, OR THE PRINCIPAL'S DESIGNEE, TO ADMINISTER THE ABOVE MEDICATION AS INDICATED. I/WE UNDERSTAND AND AGREE THAT THE SCHOOL NURSE, THE PRINCIPAL, OR THE PRINCIPAL'S DESIGNEE, SHALL NOT BE LIABLE FOR ANY INJURY TO THE STUDENT RESULTING FROM THE SELF-ADMINISTRATION OF THE MEDICATION AS AUTHORIZED BY MY SIGNATURE BELOW.

___________________________________ _________________________
Signature of Parent /Guardian Date

____
Name of Parent /Guardian (PRINT)

* One form must be completed for each medication to be administered at school, including Tylenol.

Please return to the Health Office