BRANCHBURG TOWNSHIP SCHOOLS
SCHOOL HEALTH SERVICES

MEDICATION AUTHORIZATION FORM
NON PRESCRIPTION and PRESCRIPTION DRUGS

Dear Parent/Guardian:
In accordance with school policy and state mandates, if your child **needs to take any prescription or over the counter medications during school**, the following procedure must be followed before the school nurse will administer medication to your child. **The four necessary requirements are:**

A. Provide **written physician statement** identifying the type, dosage and purpose of the medication.

B. Provide **written parent/guardian permission** for nurse to give the medication prescribed by physician.

C. Provide medication in **original labeled pharmacy container** (pharmacies will provide an extra labeled container) with the child's name, date, name of medication, dosage schedule and physician's name. Nonprescription drugs are to be in original container.

D. Parent/guardian (not the child) must bring in all medication to the school nurse.

Whiton Elementary	Stony Brook School	Central Middle School
Phone – 371-0842 Fax – 369-1582	Phone – 722-2400 Fax – 722-4201	Phone – 526-1415 Fax – 526-7486

PHYSICIAN AUTHORIZATION

I request that the Branchburg Township School Nurse administer the following medication as prescribed to:

_____Grade:_____
(Print name of pupil)

MEDICATION: Please list below:	**DOSAGE**	**HOURS OF ADMINISTRATION**	**DATE TO START**	**DATE TO DISCONTINUE**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Reason medication is being administered:_____

_____

Special Instructions:_____

Date:_____**PHYSICIAN'S SIGNATURE:**_____

PRINT PHYSICIAN'S NAME & ADDRESS:_____

DR'S FAX:_____**DR'S PHONE:**_____

PARENT/GUARDIAN AUTHORIZATION

I request that the Branchburg Township School Nurse administer the following medication as prescribed.

Date:_____**PARENT/GUARDIAN SIGNATURE:**_____

Home phone:_____**Work phone:**_____**Cell #:**_____**E-mail:**_____