ALPHA PUBLIC SCHOOL
817 NORTH BLVD.
ALPHA, NJ 08865

School Nurse
Phone: (908) 454-5000 x205 **Fax: (908) 454-4347**

PARENTAL AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING MEDICINES TO STUDENTS

DO NOT RETURN THIS FORM UNLESS YOUR CHILD IS TO RECEIVE MEDICATION AT SCHOOL

A. To be completed by the Parent or Guardian:

I request that my child _____ in grade _____ receive medication as prescribed below by our physician. The medication is to be provided in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication.

I do hereby release, discharge, and hold harmless Alpha School District, its agents and employees from any and all liability and claim whatsoever for the self-administration of the medication listed below as a result of any injury arising from self-medication.

Telephone Number _____ **Date** _____

Signature (Parent or Guardian) _____

B. To be completed by the Physician (Must be written by physician only)

I request that my patient, as listed below, receive the following medication:

Name of pupil _____ **DOB** _____

Diagnosis _____

Name of medication _____

Prescribed dosage, means of administering, time to be taken during school hours:
_____

Expected duration of treatment_____

Possible side effects and adverse reactions (if any) _____

Medication may be omitted during class trip if parent or nurse not available to administer
Please Check _____Yes _____No

Physician (please print) _____ Phone_____

Signature _____Date_____

Stamp _____