



WOODBIDGE TOWNSHIP SCHOOL DISTRICT

P.O. Box 428, School Street
Woodbridge, NJ 07095

AUTHORIZATION BY PARENT AND HEALTHCARE PROVIDER FOR ADMINISTRATION OF MEDICATION IN SCHOOL

*Authorizations are effective for one school year only and must be renewed annually.
The administration of medication to a student during school hours will be permitted only when failure to take such medication would jeopardize the health of the student or render the student unable to attend school.*

Please print all information

In order to protect the health of _____, it is necessary for him/her to have the following medication during school hours. This also includes all over-the-counter medications.

Name of Medication: _____

Student's diagnosis/purpose of medication: _____

Route/dosage/time of administration: _____

How soon can medication be repeated? _____

Length of time prescribed: _____

Possible side effects: _____

Any restrictions the medication might make on the student's daily activities (e.g., driver's education, labs, physical education): _____

If the medication is to be used on a "prn" or "as needed" basis, the order should clearly describe the conditions under which the drug is to be used: _____

Other medications the student receives that might enhance, alter or impact the effects of the ordered medication: _____

This medication is: Over-the-counter medication: Yes No
 Prescription medication: Yes No

Healthcare Provider's Signature

Date

Healthcare Provider's Stamp

I hereby grant permission to the school nurse to distribute medication to my child, _____, as described above.

Parent/Guardian Signature

Date