OLD BRIDGE TOWNSHIP PUBLIC SCHOOLS

MEDICATION AUTHORIZATION

Student Name:	DOB:
Teacher's Name:	School:

Part I: To be completed by Parent/Guardian

I give permission for my child to receive the medication listed below as prescribed by their physician.

Parent/Guardian Signature ________________________ Date __________________

Part II: To be completed by Physician

Diagnosis:	
Medication:	Dosage:
Route of administration:	Time/Frequency:
PRN: ☐ YES ☐ NO	
Duration of Treatment:	
Possible Side Effects and Adverse Reactions:	
May this medication be omitted on Field Trips? ☐ YES ☐ NO	
May this medication be omitted on Half Days? ☐ YES ☐ NO	

Physician's Name (please print):	
Phone Number:	Fax Number:

Physician's Signature: ___________________________ Date: _________________

Stamp
(09/2023)