PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

MEDICATION AUTHORIZATION

Date_____

Dear Parent/Guardian:

You have indicated that (Name)_____

(Grade)_____ is in need of medication during school hours.

It is our policy to have written permission. Please have your physician complete and return to the school nurse.

1. Pupil's name _____
2. Diagnosis _____
3. Name of medication _____

   PLEASE NOTE: An order for epinephrine may be administered by a non-medical trained delegate who is authorized to administer epinephrine ONLY. As such, antihistamines or other medications cannot be given by the delegate. Please take this into consideration when writing your order. If you have any questions in this regard, please call the school nurse listed below. Thank you.
4. Dosage of medication _____
5. Route _____
6. Time to be given _____
7. Special instructions _____
8. Side effects _____
9. Signature of physician _____
10. Physician (Please print, type or stamp) _____

    _____

    _____

    _____

    Fax No. Date

Please submit this information as soon as possible, so that the proper schedule can be maintained. If there is any change during the course of this prescribed medication, please notify the school nurse in writing.

Very truly yours,

_____ _____

School Nurse Parent's Signature

School _____ _____

Date

Phone No. _____

SN# 3
3/16