

CEDAR GROVE PUBLIC SCHOOLS

AUTHORIZATION FOR ADMINISTERING MEDICATION

Last Name _____ First Name _____

Grade _____ Date of Birth _____ Allergies _____

Section I – PARENTAL CONSENT

I am the parent/guardian of _____. I give permission for him/her to take the following medication while in Cedar Grove Public Schools. The medication is to be furnished by me in the properly labeled, original container from the pharmacy. I understand that the School Nurse will administer the medication, and/or will supervise my child with self-administering the medication. I give permission for my child to self-medicate, only if his/her physician grants permission to do so and has provided the proper instructions. I authorize the School Nurse to share information regarding this medication with the licensed prescriber. I therefore indemnify and hold the Cedar Grove Board of Education, its employees and agents, harmless from any claim that may arise out of or in connection with the administration of medication to my child. This shall include, but is not limited to, personal injury, property damage, and attorney's fees and expenses incurred in connection with litigation arising there from.

Parent/Guardian Signature Phone Contact Date

Section II – MEDICATION AUTHORIZATION (BY LICENSED PRESCRIBER ONLY)

Diagnosis: _____

Medication: _____

Duration of Treatment: _____

Child may self-medicate for asthma inhaler or EpiPen use only: YES _____ NO _____

Dosage, Frequency, and Route of Administration: _____

Please note if medication must be taken at a specific time: _____

Possible Side Effects and Adverse Reactions: _____

NAME OF LICENSED PRESCRIBER: (Please print/stamp) _____

ADDRESS: _____ PHONE: _____

PRESCRIBER'S SIGNATURE: _____ DATE: _____

SCHOOL USE ONLY:

Signature of School Physician Date