CEDAR GROVE PUBLIC SCHOOLS
AUTHORIZATION FOR ADMINISTERING MEDICATION

Last Name_____ First Name_____

Grade_____ Date of Birth_____ Allergies_____

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 # and Cell # Date

Section II. Medication Authorization (By Licensed Prescriber <u>Only)</u>

Diagnosis_____

Medication_____ Duration of Treatment_____

_____ Child may self-medicate for asthma inhaler or epi-pen 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_____

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School Physician _____ Date_____