SAINT JAMES SCHOOL
BASKING RIDGE, NEW JERSEY

AUTHORIZATION TO ADMINSTER MEDICATION IN SCHOOL
(For all prescription and non-prescription medications)

Name of Student: _____ DOB: _____ Grade: _____

Diagnosis/Illness:

_____

Medication:

_____

Dosage/Route/Frequency:

_____

Special Directions:

_____

Possible Side Effects:

_____

I certify that the above information regarding this student is correct and that the administration of the medication to this student is necessary.

_____ _____ _____

Signature of Physician Print Name of Physician Date

_____ _____

Physician Address Physician Phone Number

I/We authorize the School Nurse or, in his/her absence, the principal to administer the above medication as indicated. I/We understand and agree that the School, the School Nurse, and the Principal shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my signature below.

_____ _____ _____

Signature of Parent/Guardian Print Name Date