Midland School

Authorization for the Administration of Medication during School Hours
Valid for the School Year _____

Student Name_____ **Date Birth**_____

To Be Completed by Prescribing Physician or Advanced Practice Nurse

The above student is physically fit to attend school and is free of contagious disease. The student would not be able to attend school if the following medication is not administered during school hours.

Diagnosis: _____

Medication: _____Dosage_____Route_____

Time of administration: _____

If medication is to be given PRN, describe indications: _____

List significant side effects: _____

Length of time treatment is recommended: _____

Physician Signature _____Date:_____

Office Phone #_____

Physician Stamp (required):

To Be Completed by Parent/Guardian

I give the school nurse permission to administer the above medication to my child. I relieve the school nurse, the Rochelle Park Board of Education and its employees of any and all liability as a result of injury resulting from the administration of this medication. In addition, I give the school nurse permission to exchange confidential information, relative to the medication noted above, with my child's physician.

Parent/Guardian Signature: _____ Date: _____

***All medication must be brought to school by the parent/guardian in its original container.**