WYCKOFF PUBLIC SCHOOLS
WYCKOFF, NEW JERSEY
AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL

The following section is to be completed by the parent/guardian:

Student's Name: _____ Birth Date: _____

Address: _____ Telephone Number: _____

School: _____ Grade/Homeroom: _____

I hereby grant permission for the school nurse to administer medication to my child as prescribed below for the **school year** _____

_____ _____
Parent/Guardian Signature **Date**

The following section is to be completed by the physician:

Diagnosis: _____

Name of Medication: _____

Dose: _____

If medication is to be taken **"daily"**, at what time? _____

If medication is to be taken **"when needed"**, describe indications: _____

_____

How soon can it be repeated _____

List significant side effects: _____

Other information: _____

_____

PHYSICIAN'S STAMP

_____
Physician's Signature & Date