WARREN COUNTY TECHNICAL SCHOOL DISTRICT
1500 Route 57, Washington, NJ 07882-3538
www.wctech.org 908-689-0122

PARENTAL AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING STUDENTS MEDICATION

A. **To be completed by the Parent/Guardian:**

.

I request that my child _____ in grade_____ receive the medication as prescribed below by our physician. The medication is to be provided by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication.

Signature of Parent/Guardian _____

Address _____

Telephone number _____ Date _____

B. **To be completed by the Physician:**

I request that my patient, listed below, receive the following medication:

Name of pupil _____ Age _____

Diagnosis _____

Name of medication _____

Prescribed dosage and means of administering _____

_____

Time to be taken during school hours _____

Expected duration of treatment _____

Possible side effects and adverse reactions (if any). _____

_____

Other recommendations _____

_____

PHYSICIAN NAME (PLEASE PRINT) _____

Phone _____

Physician's signature _____