ECLC OF NEW JERSEY Homeroom_____

PHYSICIAN: INSTRUCTIONS FOR ADMINISTERING MEDICATIONS

Authorization for school nurse to administer medication in school and during off-property day and overnight trips

CHILD'S NAME: _____ Birth date:_____

MEDICATION: _____DOSAGE:_____
(NAME & STRENGTH) *(ONE MEDICATION PER SHEET)* *(DOSAGE TO BE GIVEN)*

TIMES GIVEN: _____PURPOSE:_____
(List all times)

ADVERSE REACTION(S):_____

Physician's Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Permission is hereby given for the School Nurse to administer prescribed medication to my child.

_____ _____

PARENT/GUARDIAN'S SIGNATURE: **DATE:**

PLEASE SEND THE MEDICATION IN THE PHARMACY BOTTLE WITH THE APPROPRIATE LABEL

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Int/Signature: _____ Int/Signature: _____ Int/Signature:_____