

**WATCHUNG BOROUGH PUBLIC SCHOOLS
HEALTH OFFICE**

**Bayberry School
908-755-8184
Fax # 908-755-0366**

**Valley View School
908-755-4422
Fax # 908-755-4035**

**AUTHORIZATION FOR ADMINISTRATION OF
OVER THE COUNTER MEDICATION IN SCHOOL**

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

Student's name _____ grade _____

I request that my child be assisted in taking the medication prescribed below at school by the school nurse. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse may require her presence at another location at the time the medication is needed. I do hereby release the School Board of Education, its agents and employees from liability and responsibility for adverse effects due to the administration or lack of administration of this medication.

Parent name (print) _____ date _____

Signature _____

The following section is to be completed by the practitioner:

Diagnosis for which medication is given: _____

Name of medication: _____

Dose/ frequency: _____

Any restrictions or limitations: _____

I verify that the medication is necessary for the student to fully participate in school.

Practitioner's name _____ address _____ phone # _____

Practitioner's signature _____ date _____

*** This form must be individually completed for all prescription medication.
Authorization for Medication must be completed for each school year.
Medications are to be brought to school by the parents in the original container, labeled appropriately.**

