THOMAS JEFFERSON MIDDLE SCHOOL

75 First Street • Lodi, New Jersey 07644 • Phone: (973) 478-8662 • Fox: (973) 478-0358

MEDICATION AUTHORIZATION FORM

School Year: _____ School: _____

PHYSICIAN'S ORDER

Student: _____ DOB: _____

Medication: _____ Dosage: _____

Time: _____ Frequency: _____

(If a PRN Medication please indicate the frequency with which it can be repeated)

Reason for Medication: _____

Possible Side Effects: _____

Date medication is to be discontinued: _____

Physician's Comments *(if needed):* _____

Date: _____ _____

Physician's Signature

Please Stamp

_____

Address

_____

Telephone

- -

I request that my son/daughter _____ ,be administered the Medication prescribed above by the school nurse.

Date: _____ Signature: _____

Parent/Guardian