HOLMDEL TOWNSHIP PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES PROGRAM

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS OR SCHOOL SPONSORED ACTIVITIES

A. This section is to be completed by the parent or guardian

Child's Name: _____
Last First

Date of Birth:_____ Gender: _____

Physician's Name: _____

Physician's Telephone Number: _____

_____ I request that my child be assisted in taking the medicine(s) described below at school, by legally authorized persons.

_____ I request that my child be permitted to self-administer the medicine(s), **for a *life-threatening illness,** which are described below.

**Life-threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthma attack or the use of an adrenalin injection to treat a potential anaphylactic reaction.*

Parent's/Guardian's Name: _____
(Please print)

Parent's/Guardian's Signature: _____

Home Telephone Number:_____Emergency Telephone Number:_____

B. This section is to be completed by the physician:

*****DO NOT USE THIS FORM FOR ASTHMA, FOOD ALLERGIES, BEE STING ALLERGIES*****

Name of Medicine	
Form	
Dose	
If prescribed daily, what time?	
If prescribed "when needed," describe indications	
How soon can the medication dose be repeated?	
List significant side effects	
Is this medication for a life-threatening illness?	
Is the child authorized to self-administer the medication?	
Has the child been trained by the physician?	
Length of time this treatment is recommended?	
Other information or concerns	

_____ Date:_____
(Physician's signature)

(Form Created September 2008)

PHYSICIAN STAMP: