Health Office (Revised 3/09)
North Hunterdon High School
1445 Route 31
Annandale, NJ 08801
Phone: 908-713-4171 Fax: 908-713-4403

Authorization for Medication
ONLY ONE MEDICATION PER FORM

State law requires a signed prescription by a physician that includes the information below OR completion of the form below. If a prescription is faxed, the original must be forwarded to the Health Office.

Name_____ **Grade**_____ **Date**_____

Diagnosis _____ **Allergies**_____

Medication _____

Dosage_____ **Time/Frequency**_____**Route**_____

Possible Side Effects _____

Termination date_____**(Note: State law requires that medication be renewed each school year).**

Student is free of contagious disease and physically fit to attend school.
The student would not be able to attend school unless the medication is given during school hours.

_____ _____ _____
Physician's Signature **Physician's Stamp** **Date**

Parent/ Guardian Consent for Giving Medication During School

I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of my child.

I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

_____ _____
Signature of Parent/ Guardian **Date**