

**The Health Office at Voorhees High School**

256 Route 513

Glen Gardner, NJ 08826

Phone: 908-638-2148 Fax: 908-638-6512

**Authorization for Medication - ONLY ONE MEDICATION PER FORM**

State law requires a signed prescription by a Physician/Nurse Practitioner/Physician Assistant 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)

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

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Provider's Stamp

\_\_\_\_\_  
Date

**Parent/Guardian Consent for Giving Medication During School**

I request and give consent for the School Nurse to dispense the medication prescribed by the provider 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 prescriber's name. If the medication is an over the counter medication, 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 prescriber regarding the medication listed above, if necessary.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date