SACRED HEART SCHOOL
620 Valley Brook Avenue
Lyndhurst, New Jersey 07071
(201) 939-4277

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

STUDENT NAME_____

GRADE_____ DATE OF BIRTH_____

NAME OF MEDICATION_____

DOSAGE_____

FREQUENCY GIVEN & DIRECTIONS_____

_____

PURPOSE_____

POSSIBLE SIDE EFFECTS_____

I authorize the School Nurse or her designee to administer the above medication.

_____ _____
Physician's Signature *Parent/Guardian Signature*

_____ _____
Physician's Name *Date*

_____
Address

_____

_____
Phone