Glen Ridge Public Schools Health Office

AUTHORIZATION FOR MEDICATION TO BE GIVEN IN SCHOOL

Student:		Date:	
Student: Birthdate:		School Year:	
Physician:		Phone:	
Physician address:			
Medication:		Dose:	
Route:		Time:	
Diagnosis:	Side Effects:		
For Treatment of:			
Medication to be given on:	Class trips Half day sessions	Yes	No
	Half day sessions	Yes	No
Physicians Signature			Date
*****MUST BE SIGNED	DV THE DHVCICIAN	N T	
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PARENT			
I give permission for my chi			
physician's instructions. I w	•	•	ııld's health status
changes or there is any change	ge or cancellation of th	e medication.	
Parent's Signature			Date