CHAPEL HILL ACADEMY
HEALTH OFFICE

31 Chapel Hill Road
Lincoln Park, NJ 07035
973-686-0004 x170

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOL 20__ - 20__ SCHOOL YEAR

Permission is given for the School Nurse to give the following prescription medication to my child during school hours. Medications will be provided in a Prescription labeled container.

Student Name: _____

Address:_____

City/State/Zip Code: _____

Phone # _____

Grade:_____ Date of Birth: _____

Name of Medication:_____

Dosage/Route:_____ **Administration Time:** _____

Purpose/Diagnosis:_____

Special Instructions:_____

_____ _____
Physician Signature Parent/Guardian Signature

_____ _____
Office Address Date

_____
Office Telephone Number

_____
Date (Office Stamp Please)