CRISTO REY
NEWARK HIGH SCHOOL

The School That Works!

Authorization to Administer Medication in School

Academic Year: _____

****The school nurse will not administer any medication without this completed form on file. This form must be renewed annually and is not valid without a physician AND parent/guardian signature.****

Student's Name: _____ **Grade:** _____

Allergies: _____ **Weight:** _____

A. **OVER THE COUNTER DRUGS**: Only those medications that are checked, with a dose, will be administered.

Medication	Dose	Route	Frequency	Indication
❑ Acetaminophen (Tylenol)	❑ 325mg ❑ 650mg ❑ Other _____mg	❑ Oral	❑ Every 4-6 hours as needed ❑ Other _____	❑ Pain or fever ❑ Other _____
❑ Ibuprofen (Advil/Motrin)	❑ 200mg ❑ 400mg ❑ Other _____mg	❑ Oral	❑ Every 4-6 hours as needed ❑ Other _____	❑ Pain or fever ❑ Other _____
❑ Benadryl (or generic)	❑ 12.5mg ❑ 25mg ❑ 50mg ❑ Other _____mg	❑ Oral	❑ Every 4-6 hours as needed ❑ Other _____	❑ Allergic reaction ❑ Other ❑ _____
❑ Tums (or generic)	❑ 2 tablets ❑ (1000mg) ❑ Other _____mg	❑ Oral	❑ Every 3-4 hours as needed ❑ Other _____	❑ Stomach upset ❑ Other ❑ _____
❑ Other _____	❑_____mg			

B. **PRESCRIPTION MEDICATIONS**: Only list medications that will be administrated in school.

Medication	Dose	Route	Frequency	Indication

Pages 1 & 2 MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN (over ➔)

NEW JERSEY STATE LAW MANDATES:
Policy for administration of medication in school

1. Parent or guardian shall provide a written request for the administration of any medication in school and relieving the school of responsibility for any possible adverse effects of said medication. *This must be provided each year.*

2. Pupils requiring medication at school must have a written statement from the family physician which identifies the diagnosis, the medication, the dosage, the time(s), and the number of days on which the medication is to be administered. This applies to prescription and over the counter medications, including but not limited to Tylenol and/or Advil and Benadryl.

3. Parents must assume the responsibility of delivering medication in the original container to the school nurse.

4. Medication is to be held by, and administered only by the school nurse.

5. In the absence of the school nurse, alternation in medication time schedule may be necessary.

Physician's name: _____ **Stamp**: _____

Physician's Signature: _____ **Date:** _____
(Required)

Parent's Signature: _____ **Date:** _____
(Required)