Montville Township Public Schools
Authorization for Medication to be Taken at School

The following section is to be completed by the parent:

Student's Name: _____ Sex: ____ Date of Birth_____

_____
District School Name

_____
Primary Care Provider (MD, DO, PA, APN) Address Telephone Number

I request that my child be given the following medication described below at school by the school nurse.

_____
Date Parent/Guardian Home Telephone Emergency Phone

The following is to be completed by the student's Primary Care Provider:

Diagnosis for which the medication is to be given: _____

Name of Medication: _____

Form (tablet, liquid, etc.): _____

Dosage: _____

If medication is to be given daily, at what time: _____

If medicine is given PRN, please specify: _____

Limitations: _____

How soon can it be repeated?: _____

List significant side effects: _____

Length of time medication is recommended: _____

Other information: _____

_____
Date Primary Care Provider Official Stamp