



The Titusville Academy
86 River Drive
Titusville, New Jersey 08560

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

The following section is to be completed by the **PARENT/GUARDIAN**:

Student's Name _____ DOB _____ Grade _____ Homeroom _____ I request that my child be given the medication listed below as directed by the physician at school.

Date _____ Parent/Guardian Signature _____ Telephone _____

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____ Name of medications: _____

_____ Dose: _____

If medicine is to be given "WHEN NEEDED", describe indications: _____

How soon can PRN medicine be repeated? _____ List significant side

effects: _____ Any restrictions or limitations: _____

_____ Date prescribed: _____

Date to be discontinued: _____

PLEASE CHECK THE APPROPRIATE OPTION

RE: CLASS TRIPS

_____ **YES**, the prescribed dose can be withheld on the day of the class trip. _____ **YES**, the time to be given can be adjusted with the parent/guardian. _____ **NO**, this medication must be given to the child at the scheduled time.

I verify that this child is free from contagion and this medication is necessary for the student to fully participate in the school education plan.

PHYSICIAN'S SIGNATURE _____ DATE _____

(Print) Physician's Name _____ Address _____ Telephone Number _____

This form must be completed for all medication, prescribed and over the counter. Medications are to be brought to school by the parent in the original container, labeled appropriately by the pharmacy. All medication will be kept in a locked storage area. Authorization for Administration of Medication in School Form must be completed for each school year.