WATCHUNG HILLS
REGIONAL HIGH SCHOOL

ELIZABETH C. JEWETT, PHD
SUPERINTENDENT

TIMOTHY M. STYS, CPA
BUSINESS ADMINISTRATOR

WILLIAM J. LIBRERA
PRINCIPAL

Department of Health Services
Authorization for Administration of Medication in School

NAME OF STUDENT: _____GRADE: _____DOB: _____

NAME, DOSAGE, & ROUTE OF MEDICATION(S):_____

TIME TO BE GIVEN AT SCHOOL: _____DIAGNOSIS:_____

MEDICATION START DATE:_____END DATE:_____

COMMENTS:_____

SIDE EFFECTS:_____

IS IT NECESSARY TO ADMINISTER DURING FIELD TRIPS? ❑ YES ❒NO

SIGNATURE(MD/APN/PA):_____DATE:_____

Health Office Stamp

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Authorization by Parent/Guardian

I hereby give permission for my child to receive medication at school as prescribed above by my child's physician. I understand the ultimate responsibility for administration of the medication is mine and do hereby release, discharge and hold harmless WATCHUNG HILLS REGIONAL HIGH SCHOOL, its agents and employees from any and all liability and claim whatsoever for the administration of the above medication pursuant to these directions.I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and treatment.

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

Rev 5/24

This form expires at the end of each school year