SAINT JAMES ELEMENTARY SCHOOL
30 Peters Place, Red Bank, NJ 07701
732-741-3363

AUTHORIZATION FOR SELF-CARRY and SELF-ADMINISTER MEDICINE AT SCHOOL, SCHOOL TRIPS AND AFTER-SCHOOL ACTIVITIES

PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

Name of Student ______________________________ Date _______ D.O.B. __________
Address ____ Grade _______________

Condition for which the medication is administered _______________________________

Name of medication, dose and method administered ______________________________

Time or indication for administration ____

Is this a controlled drug _____ Yes _____No

Side effects to be noted/reported ____

Other recommendations ____

Duration (dates) of administration: From ______ to _________(limit of one school year)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

____

Physician Signature Print Name Telephone Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to: carry and also self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

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Parent Signature Date Student Signature Date

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Parent Telephone Numbers