

**FLORHAM PARK PUBLIC SCHOOLS  
RIDGEDALE MIDDLE SCHOOL  
HEALTH OFFICE**  
**Phone: (973) 822-3855 x205      Fax: (973) 822-7963**

**PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION \***

In order to protect the health of \_\_\_\_\_, it will be necessary for  
(Student's Name)  
him/her to have medication during school hours, prescribed by me, as follows:

Name of medication: \_\_\_\_\_

Purpose of medication/diagnosis: \_\_\_\_\_

Mode of administration: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time of day to be given: \_\_\_\_\_

(Circle) Daily or PRN? (if PRN how soon can it be repeated) \_\_\_\_\_

Number of days given: \_\_\_\_\_ or entire school year \_\_\_\_\_

Possible side effects/instructions: \_\_\_\_\_

**I certify that the student is free of any communicable diseases and may return to school:**

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT PHYSICIAN'S NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

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**PARENTAL REQUEST**

I request the school nurse administer the above medication as directed by my physician to my child. I will supply the medication in its **original container** (prescription or over-the-counter) and notify the school nurse promptly of any change.

**Please give:** \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Child's name/grade) (Dosage) (Medication)

**at** \_\_\_\_\_ **A.M./P.M. on the following day(s)** \_\_\_\_\_

**This medication is being administered for the following reason:** \_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian's Signature)

\_\_\_\_\_  
(Date)

Authorization is effective for the current school year 2004 / 2005 only. The Board of Education will permit the dispensation of medication in school only when the pupil's health and continuing attendance in school so require and the medication is administered in accordance with the Board's policy.

A faxed copy of this form can be *temporarily accepted*, **the signed original form must follow within 7 days.**

Revised: 6/04