Kenilworth School District
426 Boulevard Kenilworth, New Jersey 07033
Telephone (908) 276-5936 Fax (908) 276-7598

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the **PARENT**

_____	_____	_____
Student's Name	Home Phone	Emergency Phone
_____	_____	_____
Physician's Name	Address	Telephone

I request that my child be assisted in taking the medicine described below at school by authorized persons.

_____ _____
Date Parent/Guardian Signature

The following section is to be completed by the **PHYSICIAN**:

Diagnosis _____
Medication_____
Dosage _____
Route_____
If medicine is to be given daily, at what time? _____
If medicine is to be given "When needed," describe indications:
_____
Possible side effects? _____
How soon can it be repeated? _____
Length of time this treatment is recommended _____
If inhaler, is child allowed to having one on his/her person? Y or N
This child is capable of and has been instructed in the proper administration of this medication. Y or N

_____ _____
Physicians Name (Print) Date

PHYSICIANS STAMP

_____
Physicians Signature