Glen Rock Middle-High School Health Office
400 Hamilton Ave
Glen Rock, NJ 07452
Phone: 201-445-7700 X 8920
Fax: 201-389-5048

Authorization for medication to be taken during school hours

Name: _____ _____ ____ _____ _____
Last First Sex Grade Date of Birth

I request that my child be administered the following medications by the school nurse. I also authorize the release of pertinent medical information to be exchanged with the appropriate professional staff involved in the care of my child.

Parent/Guardian Signature_____

Date_____

The following is to be completed by the **PHYSICIAN**.

Diagnosis: _____

Name of Medication: _____

Dose: _____

If medicine is to be given DAILY, at what time? _____

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

_____

How soon can it be repeated? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Comments: _____

_____

Date:_____ Physician's Signature:_____

Print Name:_____

Address: _____

Phone Number:_____

****All Medications must be sent to school in the ORIGINAL container labeled by the Pharmacy or Physician.**
*****Over the counter medications must follow the same procedure.**