MONTAGUE TOWNSHIP SCHOOL DISTRICT
475 Route 206 Montague, NJ 07827
V: 973 293 7131 / F: 973 293 3391 *www.montagueschool.org*

MEDICAL AUTHORIZATION FORM

TO BE COMPLETED BY PHYSICIAN

Student's Name _____ Age _____ Grade _____

Diagnosis _____

Medication _____

Dosage _____

Time of Administration _____

Possible Side Effects _____

Restrictions on Activities _____

_____ _____ _____
Physician's Name (Printed) Date Physician's Signature

TO BE COMPLETED BY PARENT

I request that my child _____ receives the medication prescribed by his/her physician. The medication is to be provided by me as required by the School Board Policy. I understand that the district is rendering a service and does not assume any responsibility of this matter. I further understand that the school nurse, or substitute school nurse, will administer the medication,

NOTE: All medication, prescribed and over-the-counter, must be brought to the school by the parent/guardian, in the original, labeled bottle or container.

_____ _____
Parent/Guardian's Signature Date