St. Thomas the Apostle School

333 Highway 18, Old Bridge, NJ 08857 (732)251-4000 x8230

# AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL (TO BE KEPT CONFIDENTIAL UPON COMPLETION)

**NAME OF STUDENT:** _____

**GRADE:** _____

**DIAGNOSIS/ILLNESS:** _____

**MEDICATION:** _____

**DOSAGE:** _____

**FREQUENCY:** _____

**SPECIAL DIRECTIONS:** _____

**POSSIBLE SIDE EFFECTS:** _____

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**I certify that the above information regarding this student is correct, and that the administration of the medication to this student is necessary.**

_____ _____

**Signature of Prescribing Physician** **Date**

_____ _____

**Address** **Phone**

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**I/We authorize the School Nurse or, in his/her absence, the Principal to administer the above medication as indicated. I/We understand and agree that the School, the School Nurse and the Principal shall not be liable for any injury to the Student resulting from the administration of the medication as authorized by my signature below.**

_____

**Signature of Parent/Guardian**

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**Signature of Parent/Guardian**

_____

**Date**