Bogert/Reynolds Schools

Health Office
391 West Saddle River Road
Upper Saddle River, NJ 07458
Phone: 201-961-6374 ♦ Fax: 201-961-9026

Authorization for Medications to be Taken During School Hours

The following section is to be completed by the **parent/guardian:**

Child's name _____ Grade & Teacher _____

Physician's name _____ Home telephone _____

I request that my child be assisted in taking the medicine(s) described below at school by authorized personnel, or be permitted to medicate him/herself as also authorized by me and my physician (see below).

Parent's signature _____ **Date** _____

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

Name of medication _____

Diagnosis/purpose of medication _____

Proper timing and dosage _____

Possible side effects _____

When medication will be discontinued _____

Activity restrictions (if necessary) _____

Is the child authorized to self-medicate? _____

Other information _____

Physician's signature _____ **Date** _____