GLEN ROCK PUBLIC SCHOOLS
CENTRAL SCHOOL
600 South Maple Avenue
Glen Rock, NJ 07452
201-445-7700
Main office: 8986 Nurse's Office: 5032
Fax: 201-389-5030

Krista LaCroix
Principal

Ellen K. Rosenberg
School Nurse

Authorization for medication to be taken during school hours

Name: _____
Last First Sex Grade DOB

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: _____

Daily Medication Time:_____

PRN Instructions/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:_____
Print or Stamp of Provider:

**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.