Bay Head School
Health Office

Frank Camardo
Principal

Michele Sierotko
School Nurse

Permission to administer prescribed and/or over the counter medication:

Student Name: ___________________________________ Grade: ________________

Medication:

1. Name of Medication: ____________________________________
   Dosage: ____
   Frequency: ____
   Reason: ____
   Route: ____
   Time of administration: ___________________________________
2. Name of Medication: _____________________________________
   Dosage: ____
   Frequency: ____
   Reason: ____
   Route: ____
   Time of administration: ____________________________________
3. Name of Medication: ______________________________________
   Dosage: ____
   Frequency: ____
   Reason: ____
   Route: ____
   Time of administration: ____________________________________

Comments regarding prescription (adverse reactions, precautions, etc.):
____
____

Physician's Name (printed): ____________________________ Phone: ____________________________

Physician's Address: ____

Physician's Signature: ____

I hereby authorize appropriate school personnel to administer prescribed medication to _______________________________ (student name). I understand the medication will be administered as per the directions of the above named physician. I will notify the school of changes or discontinuation of this medication(s).

Parent/Legal Guardian: ____ Date: _______________