WESTFIELD PUBLIC SCHOOLS
Westfield, New Jersey

DEPARTMENT OF HEALTH SERVICES

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT:

Child's name_____ School_____
Last First

_____
Physician's Name Address Telephone

I request that my child be assisted in taking the medicine described below at school by authorized persons.

I have discussed ½ days and field trip procedures with the doctor.

_____ _____ _____ _____
Date Parent/Guardian Signature Home No. Emergency No.

The following section is to be completed by the PHYSICIAN

- **Diagnosis_____**
- **Medication_____**
- **Dosage_____**
- **If medication is to be given daily, at what time?_____**
- **If medicine is to be given "When Needed", describe indications_____**
  _____
  _____
- **How soon can it be repeated?_____**
- **Length of time this treatment is recommended_____**

IS THIS MEDICATION NECESSARY ON: ½ DAY YES___NO___
IS THIS MEDICATION NECESSARY ON: FIELD TRIP YES___NO____

Other Information:

_____

_____

Date_____ Physician's Signature_____

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