FLORHAM PARK PUBLIC SCHOOLS
BRIARWOOD SCHOOL
HEALTH OFFICE
Phone: (973) 822-3884 x3002 Fax: (973) 822-0289

PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION *

In order to protect the health of_____, it will be necessary for
(Student's Name)
him/her to have medication during school hours, prescribed by me, as follows:
Name of medication:_____
Purpose of medication/diagnosis:_____
Mode of administration:_____
Dosage:_____ Time of day to be given:_____
(Circle) Daily or PRN? (if PRN how soon can it be repeated)_____
Number of days given:_____or entire school year_____
Possible side effects/instructions:_____
I certify that the student is free of any communicable diseases and may return to school:
PHYSICIAN'S
SIGNATURE:_____DATE:_____
PRINT PHYSICIAN'S
NAME:_____PHONE:_____
ADDRESS:_____
_____

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PARENTAL REQUEST

I request the school nurse administer the above medication as directed by my physician to my
child. I will supply the medication in its original container (prescription or over-the-counter)
and notify the school nurse promptly of any change.
Please give:_____, _____,
_____
(Child's name/grade) (Dosage) (Medication)
at_____A.M./P.M. on the following
day(s)_____
This medication is being administered for the following
reason:_____
_____
___
(Parent/Guardian's Signature) (Date)

Authorization is effective for the current school year 200 / 200 only. The Board of Education will permit the
dispensation of medication in school only when the pupil's health and continuing attendance in school so require and
the medication is administered in accordance with the Board's policy.
A faxed copy of this form can be temporarily accepted, the signed original form must follow within 7 days.
Revised: 6/04