High Point Regional High School
299 Pidgeon Hill Road
Sussex, NJ 07461
Phone: 973-875-3101

Authorization For Dispensing Medication

NOTE: Whenever possible, medication should be given at home to avoid disruption in students education/schedule.

TO BE COMPLETED BY PHYSICIAN: I request that my patient receive the following medication:

Name of Student:_____

School Year:_____Grade:_____

Diagnosis:_____

Name of
Medication:_____

Prescribed dosage and route of administration:_____

Time to be taken during school hours:_____

Possible side effects and adverse reactions:_____

Field Trips: Student to take medication before/after leaving school?Yes:_____No:_____

Physician's
Signature:_____

Phone number:_____ Date:_____

Physician Stamp:

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child receive the medication as prescribed by our physician in the form ordered by the doctor. I further understand that the school nurse will administer the medication. Medication must be in the original pharmacy container with students Name, Medication, Dosage, and current date. Medication will be stored in the Health Office.

Parent or Guardian
Signature_____

Phone
Number:_____Date:_____

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