Lodi High School

99 Putnam Street Lodi New Jersey 07644
Nurse Phone: 973-478-6100 xl019 Nurse's fax 973-772-2871

MEDICATION AUTHORIZATION FORM

School Year: _____ School: _____

PHYSICIAN'S ORDER

Student: _____ DOB: _____

Medication: _____ Dosage: _____

Time: _____ Frequency: _____

(If a PRN Medication please indicate the frequency with which it can be repeated.)

Reason for Medication: _____

Possible Side Effects: _____

Date medication is to be discontinued: _____

Physician's Comments *(if needed):*

_____

_____

_____

Date: _____ _____

Physician's Signature

Please Stamp

_____

Address

_____

Telephone

I request that my son/daughter _____ ,be administered the Medication prescribed above by the school nurse.

Date: _____ Signature: _____

X_____ **Date** _____ **Student picked up his/her medication as per parent/guardian.**

Student's Signature