**St. Stanislaus Kostka School**

**221 MacArthur Avenue**

**Sayreville, NJ 08872**

Tel: 732-254-5819 Fax: 732-254-7220

  **Physician and Parents Authorization**

 **Over-the-Counter and Prescription Medication(s)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Name of Student DOB Grade**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

Street Address, City, State, Zip Code Phone

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**Parent/Guardian Name Signature Date**

The following medication(s) for the above-mentioned child is (are) necessary during school hours and should be administered as follows: \***PLEASE HAVE THE PRESCRIBING PHYSICIAN COMPLETE THE FOLLOWING.**

**1**. Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Order\_\_\_\_\_\_\_\_\_

Dose\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any expected reaction\_\_\_\_\_\_\_\_ Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**. Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Order\_\_\_\_\_\_\_\_\_

Dose\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Indication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any expected reaction\_\_\_\_\_\_\_\_\_\_ Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name** phone number

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**Signature Date office stamp \*PLEASE SEND MEDICATION IN ORIGINAL PRESCRIPTION LABELED BOX**

**\*For asthma and allergy medications, complete the asthma and anaphylaxis emergency forms also**