Princeton Charter School
100 Bunn Drive
Princeton NJ 08540

Medication Authorization Form

Student's Name:_____ Birth Date:_____ Grade:_____

Address: _____

Parent Cell Phone: _____ Home Phone:_____

To be completed by the student's physician:

Medication Name: _____

Indication:_____

Dosage: _____Frequency:_____

Time medication is to be administered in school and/or under what circumstances:

_____

_____

Prescription Start Date:_____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Physician signature: _____ Date: _____

HCP OFFICE STAMP

Princeton Charter School
100 Bunn Drive
Princeton NJ 08540

Medication Authorization Form

For parent/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However in the event that I am unable to do so during school hours I hereby authorize Princeton Charter School Nurse to administer (or to allow my child to self-administer while under direct nurse supervision) prescribed medication in the manner described above.

_____ _____

Parent/Guardian printed name Parent/Guardian signature

_____

Date

For School Use Only

DATE	DROPOFF/ RETURN	MEDICATION	COUNT	RN SIGNATURE	PARENT SIGNATURE