Bogert/Reynolds Schools

**Form C**

Health Office

391 West Saddle River Road

Upper Saddle River, NJ 07458

Phone: 201-961-6374 ⧫ Fax: 201-961-9026

**Authorization for Medications to be Taken During School Hours**

The following section is to be completed by the **parent/guardian:**

Child’s name Grade & Teacher

Physician’s name Home telephone

*I request that my child be assisted in taking the medicine(s) described below at school by authorized personnel, or be permitted to medicate him/herself as also authorized by me and my physician (see below).*

**Parent’s signature** **Date**

The following section is to be completed by the **physician:**

Name of medication

Diagnosis/purpose of medication

Proper timing and dosage

Possible side effects

When medication will be discontinued

Activity restrictions (if necessary)

Is the child authorized to self-medicate?

Other information

**Physician’s signature Date**