

**Bogert/Reynolds Schools**  
Health Office  
391 West Saddle River Road  
Upper Saddle River, NJ 07458  
Phone: 201-961-6374 ♦ Fax: 201-236-9184

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

The following sections 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** \_\_\_\_\_

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