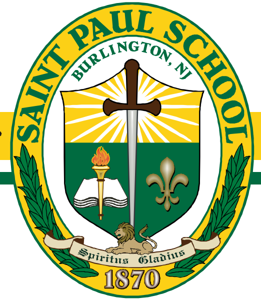
SAINT PAUL SCHOOL

Education for Tomorrow, Faith for a Lifetime



William Robbins, Principal
250 James Street, Burlington, New Jersey 08016
Tel.: (609) 386-1645 • Fax: (609) 386-1345 • www.stpaulbrl.org

Authorization for Medication to be Given During School Hours

The following section is to be completed by the PARENT:

Child's Name____ _______ _____________

Last First Sex Date of Birth

____ ____________

School Grade

____ ____________________

Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized Persons as ordered by my physician (see below).

The following is to be completed by the PHYSICIAN:
Diagnosis for which medication is to be given:____

Name of Medicine:
Form:
Dose:
If medication is to be given DAILY, at what time?
If medication is to be given PRN, how often?
How soon may the PRM medication be repeated?
Is this medication required on class trips?
List significant side effects:
Length of time medication is recommended:

Additional information: ____
____

Date: ______________________ Physician's Signature:_____________________________________