# *Delaware Valley Regional High School*

19 Senator Stout Road · Frenchtown · New Jersey · 08825-3721

Telephone: 908-996-2131 · Fax: 908-996-2198 · Website: www.dvrhs.org


## Authorization for Medication

### ONLY ONE MEDICATION PER FORM

**State law requires a signed prescription by a physician that includes the information below OR completion of the form below. If a prescription is faxed, the original must be forwarded to the Health Office.**

**Name_____ Grade_____Date_____**

**Diagnosis Diabetes Type 1 – Pump Failure Allergies_____**

**Medication_____Insulin_____**

**Dosage_____ Time(s)_____Route_____**

**Possible Side Effects: hypoglycemia; pruritus; rash; dry mouth; blurred vision_____**

**Termination date_____(*Note: State law requires that medication be renewed each school year.*)**

**Student is free of contagious disease and physically fit to attend school.**
**The student would not be able to attend school unless the medication is given during school hours.**

| _____ | _____ | _____ |
|---|---|---|
| **Physician's Signature** | **Printed Name of Physician Date** | **Date** |

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## Parent/ Guardian Consent for Giving Medication During School

**I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.**

**A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage and the prescribing**
**physician's name. If the medication is an over the counter medicine, it must be in the original box.**

**I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of my child.**

**I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.**

| _____ | _____ | _____ |
|---|---|---|
| **Parent/Guardian Signature** | **Printed Name of Parent/Guardina** | **Date** |