AUTHORIZATION TO ADMINISTER MEDICATION OR PROCEDURE FOR SIMPLE/COMPLEX INTERVENTION

To be completed by PARENT/GUARDIAN

PART A I authorize the non-public school nurse/principal/administrator to contact my primary health care provider on any questions related to my child's care. I also authorize the non-public school nurse, or other *unlicensed assistive personnel (UAP) educated by the nurse, to administer the above medication/procedure to my child during regular school hours and at other times when my child is participating in a school related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication or procedure; that I will indemnify and hold harmless The Board of Education/School District, Bergen County Department of Health Services and their employees, school, school nurse and other school employees against any claims arising from the administration of medication to my child.

Signature_____ Date_____
Parent/Guardian

To be completed by PRESCRIBING HEALTH CARE PROVIDER

PART B

NAME OF CHILD:_____ GRADE:_____

DIAGNOSIS:_____

NAME OF MEDICATION:_____

DOSAGE: _____

FREQUENCY & DIRECTIONS: _____

DESCRIPTION OF PROCEDURE: _____

PURPOSE OF DRUG/PROCEDURE: _____

POSSIBLE SIDE EFFECTS:_____

APPROPRIATE FOR DELEGATION TO *UAP: **(MUST BE CHECKED)** ☐ YES ☐ NO

Signature:_____ Date:_____
Health Care Provider

Address:_____ Telephone:_____

_____

To be completed by NONPUBLIC SCHOOL NURSE if necessary.

PART C

Orders reviewed during phone conversation with prescribing practitioner.

Signature:_____ Date:_____
Non-public School Nurse

This authorization is effective for the current school year only and must be renewed annually.