HAWTHORNE PUBLIC SCHOOLS
HAWTHORNE, NEW JERSEY 07506

School Year: _____

Dear Parents:

In order to provide effective health care for your child, it is necessary to have your physician complete this form. This will permit the school nurse to give your child medication as directed.

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Student Name: _____Date:_____

Parent/Guardian Signature:_____

Physician's Orders:_____

Dosage/Instructions:_____

Condition Requiring Medication:_____

Physician's Signature:_____

Telephone Number:_____

**Release of Information**

I authorize the sharing of medical information about my child, _____, between my child's physician or advanced practice nurse and other health care providers in the school. I also consent to the release of information contained in this plan to school personnel who have responsibility for or contact with my child, and who may need to know this information to maintain my child's health and safety.

**Parent/Guardian Signature:_____Date:_____**

EMERGENCY/SELF-ADMINISTERED MEDICATIONS

I give my permission for my child to administer his/her own medicine, as listed above, and feel he/she is capable of doing so.

Date:_____ Parent/Guardian Signature:_____