AUTHORIZATION TO ADMINISTER MEDICATION OR PROCEDURE FOR SIMPLE/COMPLEX INTERVENTION

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

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 below medication to my child during regular school hours and at other times when my child is participating in a school-related event. I understand the 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 De[artment 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: _________________

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(To be completed by **NONPUBLIC SCHOOL NURSE** if necessary.)
PART C Orders reviewed during phone conversation with prescribing practitioner.

Signature: ____________________________ (Non-public School Nurse) Date: __________