CHEDER BAIS YAAKOV of CLIFTON
...where chinuch & cheshek go hand in hand

AUTHORIZATION TO ADMINISTER MEDICATIONS/REMEDIES TO STUDENTS

School Year 2019-2020

One per child

(please make/request additional copies as needed)

Last Name: _____ First Name: _____

Grade _____ D.O.B. _____

I hereby authorize Clifton Cheder nurses, principals, or their designees to administer the following medication/remedies to my child.

Name of Medication or generic equivalent	Route	Dosage	Schedule	Mark a ✓ if you want to be contacted prior to administration	Mark an X if med is <u>not to be given.</u>
Tylenol	PO	Per labels instruction by age/weight	Every 4-5 hrs. as needed for discomfort or elevated temp		
Advil	PO	Per labels instruction by age/weight	Every 6 hrs. as needed for discomfort or elevated temp		
Benadryl	PO	Per labels instruction by age/weight	Every 6 hrs. as needed for discomfort of allergic reaction		
Chewable Anti-Acid (Tums)	PO	5-11 years: one tablet 12 yrs.+: two tablets	Every 6 hrs. as needed		
Anti-Itch Lotion (Calamine)	Topical	As needed	As needed		

_____ _____

Parent/Guardian Name (printed) Parent/Guardian Signature

_____ _____

Physician Name (printed) Physician Signature

Please note that NJ State Law requires that MD and parent sign this annually.