

**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.*