Byram Township Schools
Medication Authorization Form
For Parents/Guardians

_____
Date

_____	_____	_____	_____
Student Name	Grade & Class	Home Phone #	Emerg. Phone #
_____	_____	_____	_____
Physician Name	Phone Number	Pharmacy	Prescription #
_____	_____	_____	_____
Medication Name	Dosage & Time	Start Med. Date	Finish Date

_____

Condition requiring medication

Re-evaluation by physician if med. is continued past finish date.

The medicine is to be furnished and delivered by me in a properly labeled pharmacy bottle.
Nurse may discard empty medicine bottle ____
I will pick up medicine bottle _____ (Check one)

See P.D.R. pg._____for Reference regarding Medication

Signature_____
(Parent/Guardian)

Date_____