CHEDER | BAIS YAAKOV of CLIFTON

...where chinuch & cheshek go hand in hand

AUTHORIZATION TO ADMINISTER MEDICATIONS TO STUDENTS

School Year 2023-2024

ONE PER FAMILY

(If not all children have the same needs, please indicate clearly.)

Last Name: _____ Parents' First Names: _____

Address _____

I hereby authorize Clifton Cheder / Bais Yaakov of Clifton nurses, principals, or their designees to administer the following medication to my children.

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		
First Aid Antibiotic Ointment (i.e. Bacitracin)	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.

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