DREW UNIVERSITY HEALTH SERVICE

36 Madison Ave, Madison, NJ 07940 Tel: 973-408-3414 Fax: 973-408-3031

Name:_____ Date of birth:_____

CONTROLLED MEDICATION AUTHORIZATION

To be completed by healthcare provider. Please print clearly.

This form is for students who wish to have their controlled medication prescription for ADD/ADHD continued by Drew healthcare providers while they are at school. THIS IS NOT FOR OTHER PRESCRIPTION MEDICATIONS.

Patient diagnosis:_____

I request that the healthcare providers at Drew University Health Services continue the prescription during this student's current school year _____. I understand that each prescription will be faxed to me as produced to prevent duplicate prescriptions. Should there be any need for change of management or issues regarding this prescription please direct the student to return to me for follow up and evaluation as appropriate.

Medication Name	Administration Schedule	Last Prescription Refill Date

Please List any allergies including reaction:

Please List any other current medications and associated problem:

Examiner's Comments/Recommendations:

HEALTH CARE PROVIDER NAME, ADDRESS AND SIGNATURE REQUIRED BY NJ STATE LAW				
Name		Telephone		Stamp:
Address		Fax		
Signature		Date		

Instructions to student: This form needs to be completed each school year and is only valid during that school year as stated above. DUHS healthcare providers reserve the right to deny this prescription at any time. Please upload the completed form to your health portal: drew.studenthealthportal.com. Under Document Upload, choose "Controlled Medication Authorization Form."

The student is responsible for bringing the hard-copy prescription to the filling pharmacy and for picking up the medication, or making arrangements for in-person delivery if applicable.