DREW UNIVERSITY HEALTH SERVICE

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

Name:_____ Date of birth:_____

RESTRICTED MEDICATION AUTHORIZATION

To be completed by healthcare provider. Please print clearly.

The above patient has a diagnosis of _____ which requires ongoing prescription of the following restricted medication(s). 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 submit completed form to your web portal: drew.studenthealthportal.com.

The student is responsible to provide the hard copy prescription to the filling pharmacy and arrange for in-person delivery of medication.