CRESSKILL PUBLIC SCHOOLS

PHYSICIAN AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION

PHYSICIAN'S REQUEST

To protect the health of_____, it will be necessary for him/her to have medication during school hours.

MEDICATION_____ DOSAGE_____

TIME and/or SPECIAL CIRCUMSTANCES_____

MEDICATION_____ DOSAGE_____

TIME and/or SPECIAL CIRCUMSTANCES_____

POSSIBLE SIDE EFFECTS_____

PHYSICIAN NAME (please print)_____

PHYSICIAN SIGNATURE_____DATE_____

PARENTAL/GUARDIAN REQUEST

I hereby request that my child_____, who attends Cresskill School, be administer medication during school hours as prescribed by our family physician.

I shall provide the prescribed medication in the original container with a pharmaceutical label indicating name of student, name of prescription, dosage, time, physician's name and date prescription was issued.

PARENT/GUARDIAN NAME (please print)_____

PARENT/GUARDIAN SIGNATURE _____

SCHOOL PHYSICIAN/NURSE (please print)_____

SCHOOL PHYSICIAN/NURSE SIGNATURE_____