MIDLAND PARK PUBLIC SCHOOLS Midland Park, New Jersey

MEDICATION PERMISSION FORM (Please use one form for each individual prescription)

I hereby request the following medication to be given to my child at the prescribed time and dosage by a Registered Nurse.

Name:	Scho	ool:	
Address:		_ Age:	Grade:
			uardian Signature
ТО	BE FILLED IN BY PRIVA	ATE PHY	SICIAN
Diagnosis:			
Name of medication:			
Dosage:			
Time frame of administration	on:(earliest time)		(latest time)
Duration of administration:			
	ntion might make on the stud		y activities?
For PRN medications; con	ditions under which the drug	g is to be ı	used:
medication:	l receives that might enhanc		impact the effects of the ordered
Date	P	hysician's	Signature and stamp
Date		School Ph	ysician's Signature

Please note:

- 1. Medication is to be brought to school by the parent/guardian in the <u>original</u> container, labeled by the pharmacy.
- 2. All medications will be kept in a locked storage area.