Edward H. Bryan School
Fax: 201-569-3367

CRESSKILL PUBLIC SCHOOLS

PHYSICIAN AND PARENT REQUEST FOR THE
ADMINISTRATION OF MEDICINE
Over the Counter and Prescription

PHYSICIAN'S REQUEST

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

Allergy (if applicable) _____

1) MEDICATION _____ DOSAGE _____
TIME and/or SPECIAL CIRCUMSTANCES _____

2) MEDICATION _____ DOSAGE _____
TIME and/or SPECIAL CIRCUMSTANCES _____

Possible side effects of medication _____

Physician's Name _____
(Please print)
Address _____ Phone Number _____

Physician's Signature _____ Date _____

PARENTAL/GUARDIAN REQUEST

I hereby request that my child _____, who attends Edward H. Bryan School, be administered medication during school hours as prescribed above by our family physician.

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

Parent/Guardian (Please print) _____Date _____

Parent/Guardian Signature _____