Merritt Memorial School
Fax # 201-569-3862

CRESSKILL PUBLIC SCHOOLS

PHYSICIAN AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICINE (Prescription and/or Over the Counter)

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 # _____

Physician's Signature _____ Date _____

PARENTAL/GUARDIAN REQUEST

I hereby request that my child _____, who attends Merritt Memorial School, be administered medication during school hours as prescribed above by our 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 an date medication was issued to my child.

Parent/Guardian (Please print) _____ Date _____

Parent/Guardian Signature _____