WEST MILFORD PUBLIC SCHOOLS
HEALTH SERVICES
Physician Request for Dispensing Medication during School Hours
(To be Renewed Every School Year)

Please Print:

Student's Name:_____ DOB: _____

Parent's/Guardian's Name:_____

Address: _____

School: _____Grade:_____

Diagnosis: _____

Medication _____Dosage: _____Times:_____

If PRN, how often can it be repeated? _____

Significant side effects: _____

Length of time for treatment: _____

Other medicine the child is taking at home: _____

Special instructions: _____

Date: _____ Physician's Signature: _____

Physician's Stamp: _____

*******Parent/Guardian Request*******

I hereby request and authorize the school nurse to dispense the medication(s) as indicated above. I release and hold harmless the Board, its agents, and employees from any and all liability for injuries or other damages which result from administration of the medication.

Date:_____ Parent/Guardian Signature:_____

cf/9/2014