Garwood Public Schools
Garwood, New Jersey

Request for Medication

Doctor, please complete and sign:

Student Name ____________________________________ **Date** _____________

Address ____ **D.O.B.** ___________

I authorize that ______________________________ **be given** ___________________
(Name of Student) (Medication)

________________ **at** _____________________ **for** _____________________________
(Dosage) (Hour of Day, PRN) (Length of Time)

Diagnosis ____

Side Effects ____

Indications for prn medication ____

___________________________________ ____________________________________
Physician Name (Print) Signature of Physician

Student may skip medication dose on field trip days

___________________________________ ____________________________________
Physician Name (Print) **Signature of Physician**

Parent, please complete and sign:

I give my permission for _________________________________ **to receive the above**
(Name of student)
medication. I understand that the Garwood Board of Education and its employees or agents shall incur no liability as a result of any injury arising from the administration of this medication.

__________________________________ ________________
Signature of Parent/Guardian Date

NOTE: ***Request for medication must be renewed each school year. Medications must be brought to school by an adult in the original container.***