

**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: _____

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: _____

_____ Medication must be administered during the school day or the pupil would not be able to attend school. The student is also free of contagious disease.

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: _____