

Wayne Health Department Non Public Schools
Wayne, New Jersey
School Health Services

To: School Nurse

Date: _____

Re: _____

Medication: _____

Dosage: _____

Time of Administering: _____

Period of Time: _____

Purpose of Medication: _____

Possible Side Effects Which May Affect School Performance _____

REVIEWED BY SCHOOL MEDICAL INSPECTOR PRESCRIBING PHYSICIAN'S SIGNATURE



PARENTS REQUEST FOR ADMINISTRATION OF PRESCRIPTION AND NON-
PRESCRIPTION
MEDICATION AT SCHOOL

I request the school nurse to administer to my child _____ the
medication

_____	_____	_____
Name of Medication	Dosage	Time to be given

Reason for medication:

With medication, prescribed by Dr. _____ for the period from _____ to

Date Date

The medication is to be provided to me in the original labeled container.

To my knowledge, my child is not allergic to this medication.

I hereby relieve the Wayne Health Department and Non-Public School Nurse of any and all liability,
which may result from administration of the medication to my child.

Parent/Guardian Signature

Date _____
School _____

REVIEWED BY SCHOOL MEDICAL INSPECTOR

H/non public school nursing/Wayne Health Dept.