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

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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.