Garwood Public Schools
Garwood, New Jersey

# Request for Medication

*Doctor, please complete and sign:*

**Student Name** ________________________________________**D.O.B.**___________ **Date** __________

**I authorize that** _____________________________**be given** ____________________
(Name of Student) (Medication)

__________ **at** ____________________ **for** _________________________________
(Dosage) (Hour of Day, PRN) (Length of Time)

**Diagnosis and side effects**_______________________________________________

**Indications for prn medication** ____________________________________________

_______________________________ _____________________________________
Physician Name (Print) Signature of Physician

*Parent, please complete and sign:*

**Medication dose on field trip days**
______maybe omitted _____ will adjust my child's schedule ____ is life-threatening and cannot be skipped.

**Medication dose for Early Dismissal Days**
_____ omit dose, mediation will be given at home _____ administer medicine as ordered

**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. All medications should be picked up by an adult at the end of the school year. Any medications left in the health office will be discarded.**