1st Cerebral Palsy of NewJersey
Unique needs deserve a unique school

Request for Medication to be Administered by School Nurse

Parent/Guardian Request

I, the Parent/Guardian of ______________________________ requests that the School Nurse administer the medication prescribed by my child's physician to ray child at the prescribed time.

I agree to provide the school with a monthly supply of the medication in a properly labeled prescription bottle.

Date	Phone
Address	Signature of Parent/Guardian

Physician's Statement

In order to protect the health of ______________________________

it is necessary for him/her to have the following procedure medication during school hours.

Medication	Dosage & Route
Times to be administered	Purpose of Medication
Possible Side Effects	Allergies
Diagnosis	

I authorize the school nurse to administer this medication.

Date	Phone
Address	Signature of Physician & Stamp