CHERRY HILL PUBLIC SCHOOLS
MEDICATION AUTHORIZATION FORM

I request the enclosed medication, in the original container to be administered to my child and shall release school personnel from all liability.

Name of Student _____ DOB _____

Grade /Team/Graduation Year _____

Name of Medication _____

Dosage _____

Diagnosis/Purpose _____

Parent's Signature _____ Date _____

Home #: ( ) _____

Cell #: ( ) _____

Work #: ( ) _____

TO BE COMPLETED BY PHYSICIAN ONLY [FOR ALL OVER-THE-COUNTER & PRESCRIPTION MEDICATIONS]:

With exception of Tylenol (Acetaminophen) & Advil/Motrin (Ibuprofen)

Name of Medication: _____

Dosage: _____

Diagnosis/Purpose: _____

Comments: _____

Physician's Signature _____

Physician's Name (print) _____

Phone _____

Date _____

Physician's Stamp

This form is only valid for the present academic year.

09/2013