CHERRY HILL PUBLIC SCHOOLS

Cherry Hill, New Jersey

Permission Slip

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 Child: _____ Date: _____

Name of Medication: _____ Date of Birth: _____

Dosage: _____

Purpose: _____

Signature Parent/Guardian: _____

Phone Home:_____Cell:_____Work:_____

TO BE FILLED IN BY SCHOOL NURSE ONLY:

Prescription#/Medication:_____

Pharmacy: _____Pharmacy phone#: _____Date: _____

TO BE FILLED IN BY PHYSICIAN ONLY:

Name of Patient: _____

Name of Medication/Prescription: _____

Dosage: _____

Purpose: _____

Comments: _____

Name of Physician (printed): _____Signature:_____

Physician's Phone: _____Date: _____

NOTE: Include medication prescribed by a physician and all "over the counter" medication.