CREST MEMORIAL PUBLIC SCHOOL

9100 PACIFIC AVENUE WILDWOOD, NEW JERSEY

Kim Sorensen , School Nurse Phone 609-522-1522 Fax 609-522-2047

MEDICATION ADMINISTRATION

I give permission for the school nurse to give medication to my child,

_____, during school hours. The medication is to be furnished by me in the original container with the original store or pharmacy label intact.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

Student's Name_____

Diagnosis_____

Medication_____

Potential medication effects_____

Dosage and time of administration_____

_____

(Please clarify if PRN, describe conditions under which drug is to be administered)

List restrictions, if any, on daily activities while on medication

(e.g. Drivers' education, physical education)_____

List other medications the student receives that might enhance, alter or impact the efficacy of other prescribed medication:

Physician's Signature:_____Date:_____