

CRANFORD PUBLIC SCHOOLS
Cranford, New Jersey

MEDICATION, DOCTOR'S ORDERS AND PARENT'S PERMISSION

Doctor: Please complete and sign:

Students Name: _____ Date: _____

Street Address: _____ D.O.B. _____

I authorize that _____ be given _____
(Name of Student) (Medication)
_____ at _____ for _____
(Dosage) (Hour of Day) (Length of Time)

Diagnosis: _____

Side Effects: _____

Special circumstances to indicate need for PRN medication: _____

Physician Name (Print)

Physician Signature

I understand that the Cranford Board of Education and its employees or agents shall incur no liability as a result of any injury arising from this medication.

Parent Signature

Parent: Please complete and sign:

I give permission for my child _____ to receive
the above medication. (Child's Name)

Parent Signature

Note: Request for medication shall be renewed each school year.