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 Phone #: ____

Cell Phone#: ____

Work Phone #:____

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: ____

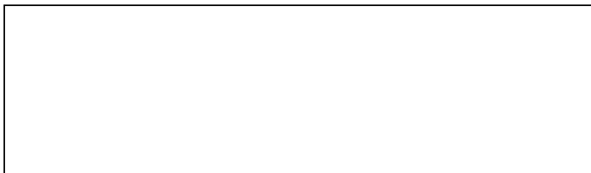
Comments: ____

____

Physician's Signature: ____

Physician's Name (Print): ____

Phone #:____ Date: _____________________________



Physician's Stamp

This form is only valid for the present academic year.