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: (With exception of Tylenol & Motrin)

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 except Tylenol and Motrin.