PARK RIDGE PUBLIC SCHOOLS
PARK RIDGE, NEW JERSEY

REQUEST FOR THE ADMINISTRATION OF MEDICATION AT CAMP BERNIE

NOTE: This refers to any prescription drug or over-the-counter medicine. All medication must be clearly labeled and in the original container. Medicine must be promptly claimed by a parent upon return to school.

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THE FOLLOWING SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN

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Student's Name: Last First Grade/Teacher Date of Birth

____
Physician's Name Address Phone Number

I request that the school nurse administer the medicine listed below to my child, or that he/she be permitted to self-administer with the Doctor's permission (APPLIES TO LIFE THREATENING ILLNESSES ONLY).

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Date Signature of Parent/Guardian Home Phone Cell Phone Work Phone

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THIS SECTION IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis for which the medication is prescribed: ____
____
Name of Medication: ____
Form: ____
Dose: ____
If Medication is Daily, what time?: ____
If Medication is "When needed", describe indications: ____
____
Can it be repeated? ______________________ How soon after initial dose? _________________________
Significant Side Effects: ____
____
Duration of Treatment: ____
Student May Self-Medicate (Life Threatening Illnesses Only): ____________________________________
COMMENTS/OTHER INFORMATION: ____
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____

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Date Signature of Physician