Clifton Public Schools
Health Services

Dear Parents/Guardians;

We are writing to ask your cooperation with our efforts as we attempt to best serve the school-age child regarding the administration of medication during school hours. State law prohibits students from having medication in their possession and from administering their own medication. If the school nurse is to administer the medication, parental permission and a written statement from the physician prescribing the medication is required. This mandates applies to all herbal and non-prescription medications also.

Parent's Request for Administration of Medicine at School

School _____ Student ID number _____

I request that my child_____ DOB_____ Grade____
(Child's name)
receives the medication prescribed by _____for the
(Physician's name)
period from _____to _____.

_____ _____
(Parent/Guardian Signature) (Date)

Physician's Request for Administration of Medication at School

Name of Student _____Date_____

Name of Medication _____ Time of Administration_____

Dosage _____Reason for Medication_____

The student should take this medication on: 1.Field Trips Yes_____ No_____
2. Early Dismissals Yes_____ No_____

Possible Side Effects_____

Physician's Signature_____

Physician's Name_____

Physician's Address _____Phone #_____

(Please complete all information and use address stamp)

Parent/Guardian: Please bring medication to school in a pharmacy container labeled with child's name, drug name, dosage, specific time to be given and prescribing physician's name to assure the correct identification of the drug.

Thank you for your cooperation in this matter.

Date_____Approved by School Physician_____

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