Central Presbyterian Church Weekday Nursery School & Kindergarten

70 Maple Street, Summit, NJ 07901

Authorization For Medication During School Hours

Date:___________________________

My child,___________________________________, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medicine in an appropriately labeled, original pharmacy container.

Name of Medication: ______________________________

Prescribed Dosage: ______________________________

Time Schedule: ______________________________

Physician: ______________________________

Physician Telephone Number: ______________________________

Pharmacy: ______________________________

Pharmacy Telephone Number: ______________________________

List side effects of medication:

____

Diagnosis and necessity of medication during school hours:

____

Expected duration of medication regime: ______________________________

I do hereby release, discharge and hold harmless, CPC WNS&K, its teachers and staff, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

Medication will not be sent on field trips unless specific arrangements have been made beforehand.

Parent Signature:____

Physician Signature:____

08/23/2012