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(s) 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 medications (if any):

Diagnosis and necessity of medication during school hours:

Expected duration of medication regime:

I do 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:

Contacts:

Call 911 (Rescue Squad): ( ) - Doctor: | Phone: ( ) -

Parent/Guardian: Phone: ( ) -

Other Emergency Contacts:

Name/Relationship: Phone: ( ) -

Name/Relationship: Phone: ( ) -