



HUNTERDON PREPARATORY SCHOOL

11 SPENCER LANE

ANNANDALE, NJ 08801

Phone: 908-832-7200 • Fax: 908-832-9772

www.hunterdonprep.org

Parent's Request for Giving Prescription Medications at School 2018/2019

During school hours, I request that my child _____ receive

(Student Name)

_____	_____	_____
(Name of Medication)	(Dosage)	(Time)
_____	_____	_____
(Name of Medication)	(Dosage)	(Time)
_____	_____	_____
(Name of Medication)	(Dosage)	(Time)
_____	_____	_____
(Name of Medication)	(Dosage)	(Time)

I understand that the **medication must be delivered to the school nurse**, principal, and/or designee. It **must be in a properly labeled container** (pharmacy label) with my child's name, the physician's name, date of original prescription, name of medicine, dosage, and time to be given.

I further understand that in the event that the school nurse or designee is **not** available, it may be necessary to delay or omit the administration of the medications. The Hunterdon Preparatory School staff will make every effort to alert me in this instance. I will not hold any individual staff member liable who is directed by us (the parents/guardians) and the school administrator to assist our child in taking said medication.

(Signature of Parent/Guardian)

(Date)

PHYSICIAN

Diagnosis or indication for medication: _____

Precautions, if any: _____

Signature of physician/license #: _____

Address: _____