Glen Rock Middle-High School Health Office 400 Hamilton Ave Glen Rock, NJ 07452

Phone: 201-445-7700 X 8920 Fax: 201-389-5048

Authorization for medication to be taken during school hours

Name:				
Last	First	Sex	Grade	Date of Birth
I request that my child be active release of pertinent medinvolved in the care of my c	ical information to be hild.	exchanged with	the approp	riate professional staff
	Parent/Guar	dian Signature_		
The following is to be comp		Date		
Diagnosis:				
Name of Medication:				
Dose:				
If medicine is to be given D	AILY, at what time?			
If medicine to be given "WI	HEN NEEDED," desc	ribe indications:		
How soon can it be repeated	1?			
List significant side effects:				
Length of time this treatmer	nt is recommended:			
Comments:				
Date:	Physician's Signatu	re:		
	Print Name:			
	Address:			
	Phone Number:			

 $\ ^{**}All$ Medications must be sent to school in the ORIGINAL container labeled by the Pharmacy or Physician.

^{***}Over the counter medications must follow the same procedure.