Marie H. Katzenbach School For The Deaf
Student Health Center
P.O. Box 535
Trenton, NJ 08625-0535
Voice 609-530-3167 / TTY - 609-530-3169 / Fax - 609-530-3168

Date:_________________________________

Dear School Nurse:

I/We hereby request permission for my/our child _______________________ to be *given* prescription medication at school and in doing so, release the Health Center nurses and physician of all responsibility for any adverse reactions my child may incur as a result of taking the medication.

I will send the appropriate amount of the medication with a prescription label to the school.

Last dose of medicine given at: ____
(Date & Time)

Parent(s)/Guardian(s) Signature(s):____

* * * * * * * * * *

This section to be completed and signed by doctor

Diagnosis____

Name of Medication ____

Dosage ____

Time Medication Should be Taken ____

Beginning Date is ________________________ Last Day is________________________

Possible Side Effects ____

Physician's Signature ____ Date____________________

Physician's Name (Typewritten or Printed) ____

Physician's Telephone Number ____

Any Activity Restriction? ____ Until? _________________