NEW MILFORD HIGH SCHOOL
NEW MILFORD, N.J.
Telephone 201-262-0172 ext. 2002
Fax # 201-262-4445 or 201-634-0547

To Whom It May Concern:

_____must receive medication during school
Student's Name

During school hours from _____ to _____.
Date Date

Name of Medication_____

Dosage_____

Time of Administration_____

Diagnosis_____

Comments: _____

_____

_____

_____
Physician

I hereby give permission for my child_____

to be given the above medication in school and will assume any responsibility for any reaction that may occur.

_____
Parent's Signature

(PLEASE NOTE THAT A NEW MEDICATON FORM NEEDS TO BE FILLED OUT EACH CALENDER SCHOOL YEAR) THANK-YOU.