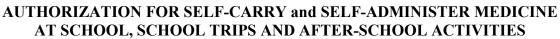


## SAINT JAMES ELEMENTARY SCHOOL

30 Peters Place, Red Bank, NJ 07701 732-741-3363



## PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER

Name of Student		Date	D.O.B	
Address		Grade		
Condition for which the med	dication is administere	ed		
Name of medication, dose a	nd method administer	red		
Time or indication for admir	nistration			
Is this a controlled drug	YesNo			
Side effects to be noted/repo	orted			
Other recommendations				
Duration (dates) of administ	ration: From	to(li	mit of one sch	ool year)
IN MY OPINION, THIS STUD ABOVE MEDICATION.	ENT SHOWS CAPABII	LITY TO CARRY	AND SELF-AI	OMINISTER THE
Physician Signature	Print Name		Telephone	Date
PA	ARENT/GUARDIAN	AUTHORIZA	ATION	
I request that my child, named ab- take responsibility for this permis labeled with name of student, pre- strength and dose of medication; a	sion. I understand that the scribing health care provide	medication must be	e in the original p	harmacy container,
Parent Signature	Date	Student Signature	Date	
Parent Telephone Numbers				