Saint Benedict School
165 Bethany Road
Holmdel, NJ 07733-1699
(732) 264-5578

First Day of School _____ to August 31, _____

Student _____ Grade _____

PART I TO BE COMPLETED BY STUDENT'S PHYSICIAN

I certify that this school must administer medication listed below to my patient.

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE/MODE/FREQUENCY:_____

POSSIBLE SIDE EFFECTS: _____

_____

Physician's Signature

Printed name of physician: _____

Phone Number:(_____) _____

Date: _____

PART II COMPLETED BY STUDENT'S PARENT/GUARDIAN

I request that the medication listed above be administered to this student in school. I understand that only I, or the school nurse may administer this medication in school to this student. I acknowledge that the school shall incur no liability as a result of any condition from the medication. I shall indemnify and hold harmless the school, its employees or agents against any claims arising from the administration of medication by this student.

_____

Signature of Parent/Guardian

_____ _____

Printed name of Parent/Guardian Date