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HOPE TOWNSHIP SCHOOL DISTRICT

P.O. Box 293, 320 Johnsonburg Road, Hope, N.J. 07844
Telephone 908-459-4687 Fax 908-459-5553

PERMISSION FORM (PART 11)

Physician's Certified Statement for the Administration of Medication

- A. Student Name _____
- B. Name of Medication _____
- C. Purpose of Medication _____
- D. Time and Dosage _____
- E. Possible Side Effects _____
- F. Time when Medication
is to be discontinued _____

I certify that the above student is physically fit to attend school and is free of contagious disease and would not be able to attend school if the medication is not administered during school hours.

Physician's Signature

Date