

TIMOTHY CHRISTIAN SCHOOL
2008 Ethel Road, Piscataway, N.J. 08854
Phone (732) 985-0300, ext. 618 Fax (732) 248-4271

Physician and Parent Authorization
Over-the-Counter and Prescription Medication(s)

Name of Student _____ Grade _____

Street Address, City, State, Zip Code _____ Phone Number _____

The following medication(s) for the above-mentioned child is (are) necessary during school hours and should be administered as follows:

1. Name of medication _____ Date of order _____

Dose _____ Time _____ Indication _____

Can a reaction be expected? _____ If so, describe _____

2. Name of medication _____ Date of order _____

Dose _____ Time _____ Indication _____

Can a reaction be expected? _____ If so, describe _____

Parent or Guardian Signature

Physician Signature

Physician Office Stamp

