

LINDEN PUBLIC SCHOOLS
DEPARTMENT OF MEDICAL INSPECTION
ACADEMY OF SCIENCE & TECHNOLOGY
128 WEST ST. GEORGES AVENUE
LINDEN, NEW JERSEY 07036

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Superintendent

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MEDICATION VERIFICATION

I, as parent and/or legal guardian, hereby request that my child _____ be given medication by a representative of the Linden Board of Education in accordance with the below listed instructions of Dr. _____

Date

Parent or Legal Guardian
(designate which)

Please administer medication to the following student:

Name _____
Address _____
Date of Birth _____

DIAGNOSIS: _____
MEDICATION: _____
DOSAGE: _____
TIME: _____

Date

Physician