# WOOD-RIDGE SCHOOL DISTRICT

**(201) 933-6777**

PHYSICIAN'S CERTIFICATION

ADMINISTRATION OF MEDICATION

I, _____, am a licensed physician in the State of New Jersey.

I certify that my patient, _____, requires that medication be administered to said patient by the school nurse. I hereby provide the following information.

Diagnosis:_____

Medicine: _____

Form: _____

Dose: _____

If medication is to be given daily-please indicate the time_____

If medication is to be given as needed, please indicate the reason _____

Please indicate any significant side effects _____

Date: _____

Physician's Signature _____