

Please print clearly as this form will be scanned into the patient record by Drew University Health Services.  Dear Sir or Madame:  The applicant has a diagnosis of	Name:				Birth date:	/	_/
Drew University Health Services.  Dear Sir or Madame: The applicant has a diagnosis of  which requires ongoing prescription of the following restricted medication(s). I request that the healthcare providers at Drew University Health Services continue the prescription during this student's current school year	Last <b>Please r</b>	First Print clearly as this	form will be	Middle scanned in	Month to the nationt rock		Year
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in one envelope to: **DREW UNIVERSITY HEALTH SERVICES, 36 Madison Ave, Madison, NJ 07940.** 

The student is responsible to provide the hard copy prescription to the filling pharmacy and arrange for in-person delivery of medication.

this prescription at any time. Please complete and mail all completed, signed documents together