

MOUNT LAUREL TOWNSHIP PUBLIC SCHOOLS
Permission for the Dispensing of Medication



Physician Section

To: School Nurse _____ Date: _____
From: Physician Name: _____ Physician telephone #: _____

Student Name: _____

The above mentioned student is under my medical care. His/her treatment requires dispensing medication as stated below. Please allow this patient to adhere as closely to his/her schedule as possible. He/she must take the medication in the school nurse's office.

Diagnosis: _____

Specific Instructions: _____

Medication _____ Dosage _____

Time to be given _____ School year _____

List any precautions and/or Side Effects _____

Physician's Signature _____ Physician's Stamp

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Parent/Guardian Section

I the Parent/guardian of _____, a student in Mount Laurel Public Schools hereby give permission to the school nurse to administer medication to my child as prescribed by the above referenced physician.

I understand that all medication including over the counter medication is to be brought to the nurse by the parent or legal guardian. **Under no circumstances can medication be sent to school with a child.**

Parent/guardian Signature _____ Date _____