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Permission for the Dispensing of Medication

Physician Section

To: School Nurse Date: ______________________

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: