Mount Laurel SCHOOLS
330 Mount Laurel Road • Mount Laurel, NJ 08054 • Phone: 856-235-3387 • Fax: 856-787-9692

Inspiring potential. Enriching futures.

TO: School Nurse

FROM: Physician Name: _____Physician Phone: _____

STUDENT NAME: _____

PHYSICIAN SECTION

The above names 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 health office.

Diagnosis: _____
_____

Specific Instruction: _____
_____

Medication: _____Dosage: _____

Time to be given: _____ _School Year:_____

List any precautions and/or side effects: _____

_____
Physician's Signature

Physician's Stamp

PARENT SECTION

I, the parent/guardian of _____, a student in Mount Laurel Township 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 must be brought to the school nurse by the parent/guardian. Under no circumstances can medication be sent to school with a child.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____ _____
Phone Date