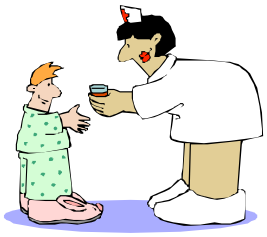
MOUNT LAUREL TOWNSHIP PUBLIC SCHOOLS
Permission for the Dispensing of Medication



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

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 _____