MOORESTOWN TOWNSHIP PUBLIC SCHOOLS
MOORESTOWN, NEW JERSEY

TO: SCHOOL NURSE

FROM: DR.____________________________ TELEPHONE_____________________

ADDRESS____

RE: STUDENT'S NAME____

This 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 medication schedule as possible. He/she must take the medication in the school health office.

DIAGNOSIS____

MEDICATION____DOSAGE___________________

ADMINISTRATION TIME(S) AT SCHOOL_______________ NUMBER OF DAYS_____________

PRECAUTIONS/SIDE EFFECTS____

_______________________ Date

____ Doctor/NP Signature

As parent or (legal guardian) of ____, a student in the ______________________________ School, I hereby request the school authorities to allow my child to take medication during school hours as prescribed by Dr._____________________________.

I understand the medication will be brought to school with a written prescription on the container.

Thank you.

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Signature of Parent/Guardian