ADMINISTRATION OF MEDICATION

Moorestown Township Public Schools
Moorestown, New Jersey

TO: School Nurse

FROM: Dr _____

Address: _____

Telephone: _____

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: _____

Provider stamp

_____

Doctor/NP Signature Date

As parent (or legal guardian) of _____, a student in the Moorestown Township Public Schools, I hereby request the school authorities to allow my child to take medication during school hours as prescribed by Dr. _____.

Thank you.

_____

Signature of Parent/Guardian Date

Revised 10/2019