

**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 \_\_\_\_\_

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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 \_\_\_\_\_