West Deptford Township Schools

Effective School year _____ School _____

Student's Name _____ Grade _____

Dear Parent/Guardian:

Board policy states that students who need to take medication every day for the entire school year, must have the doctor's authorization renewed every year. **Also, the medication must be brought in and picked up by an adult.** Medications may not be carried by students on their person unless they qualify under the policy for self administration. All medication must be in a labeled container from the pharmacy.

To be completed by Physician

Please administer the following medication(s) to _____
(Name of the student)

for the purpose of treating _____.
(Diagnosis)

Name of Medication:	**Dose/Route:**	**Time:**	**Side Effects:**
_____	_____	_____	_____
_____	_____	_____	_____

Other medications taken by the student which might interfere with the effects of the ordered medication_____.

_____ _____
Physician's Name (please print) **Phone Number**

_____ _____
Signature of Physician **Date**

To be completed by Parent/Guardian

Should this medication be given on a ½ day of school? _____

I give permission for my child to receive the above medication(s) as directed by the physician and according to school policy.
I authorize the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above.

_____ _____
Signature of Parent **Date**