EVESHAM TOWNSHIP SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

MEDICATION ORDER by PHYSICIAN

Student Name: ____

Medication: ____

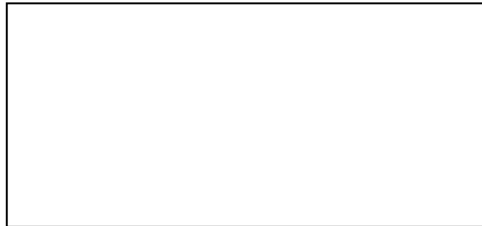
Dosage : ____ Time:___________________

Reason for medication:____

Yes_____ No_____ If the morning dose of this medication is missed at home, the school nurse may give it per parent's request. Later dose time to be adjusted accordingly.

_______________________________________ _______________________
Physician Signature Date

Office Stamp



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Parent Permission

As the parent/guardian of the student listed above, I authorize the school nurse to administer this medication during school hours as prescribed. I understand that all medication must be brought to school in the original pharmacy container with label. Over-the-counter medicine must be in the original container. No medication will be given without the written permission of the physician and the parent/guardian.

My child will ________ will not ___________ take this medication on early dismissal days.

I will accompany my child to administer this medication on field trips, or I will consult with the school nurse to revise the medication schedule on field trip days or make other arrangements.

____ _________________________
Parent /Guardian Signature Date