# FORM 2

# 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 effect of the ordered medication: _____

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

_____ _____
Signature of Physician Date

**To be completed by Parent/Guardian**

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