STERLING HIGH SCHOOL DISTRICT

501 S. WARWICK ROAD, SOMERDALE, NEW JERSEY 08083-2175
PHONE (856) 784-1333 FAX (856) 784-7661

TO: SCHOOL NURSE

FROM: DR. _____ TELEPHONE _____

ADDRESS _____

RE: STUDENT'S NAME: _____ DATE _____

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 _____

SPECIFIC INSTRUCTIONS _____

MEDICATION _____ DOSAGE _____

PRECAUTIONS/SIDE EFFECTS _____

_____
DOCTOR'S SIGNATURE

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

I understand the medication will be brought to school with written permission on the original container.

_____
Signature of parent/guardian

DATE: _____

jj