SALISBURY TOWNSHIP SCHOOL DISTRICT/ST. THOMAS MORE SCHOOL HEALTH SERVICES
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

FOR THE PHYSICIAN/Legal Prescriber

_____must receive medication prescribed by me for the following

_____

_____

This medication must be given during school hours in order to maintain sufficient health and participation in the school program.

Medication _____
Prescribed SCHOOL dosage _____
Time to be given in school _____
Duration period _____
Possible side effects_____

_____ _____
Date Signature of physician Legal prescriber

THIS ORDER IS VALID FOR ONE SCHOOL YEAR ONLY

FOR THE PARENT OR GUARDIAN:

_____must receive the following medication during school hours in order to maintain sufficient health and participation in the school program.

Medication_____
Prescribed school dosage_____
Time to be given in school _____

I authorize the administration of the medication ordered by the prescriber above by the school nurse or other authorized personnel of STM or STSD. I authorize ST.Thomas More School and the above named prescriber to exchange health related information in regards to the care of my child. I agree to deliver the medication to the school health room unless it is an asthma inhaler, antibiotic, or over the counter medication which my child may deliver to the health room upon arrival to school.

_____ _____
Date Signature of Parent or Guardian