

WATERFORD TOWNSHIP PUBLIC SCHOOLS

Atco Elementary

Thomas Richards

Waterford Elementary

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Superintendent of Schools

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School Year: 2016 – 2017

B-PHYSICIAN

**WATERFORD TOWNSHIP PUBLIC SCHOOLS
MEDICATION DISPENSING AUTHORIZATION
PHYSICIAN'S AUTHORIZATION**

The student listed below is under my medical care. His/her treatment requires dispensing medication during school hours as stated below:

STUDENT'S NAME _____ SCHOOL _____

REASON FOR MEDICATION [DIAGNOSIS] _____

NAME OF MEDICATION _____

Prescription Non Prescription

DOSAGE _____

TIME TO BE ADMINISTERED _____

ROUTE OF ADMINISTRATION _____

SPECIFIC INSTRUCTIONS _____

PRECAUTIONS/SIDE EFFECTS _____

OTHER MEDICATIONS STUDENT IS TAKING _____

Signature of Physician

Date

Print Name of Physician

Phone Number

B - PARENT/GUARDIAN

PARENTAL/GUARDIANSHIP PERMISSION

Medication has been prescribed for my child/ward _____.

As a parent/guardian I hereby request the administration of medication described medication described above to my child/ward and release the Waterford Township School District and its employees of any responsibility of liability in giving this medication. I understand that the medication must be in the original container and be properly labeled. I also understand that medication not picked up by the last day of school in June will be discarded.

Date

Signature of Parent/Guardian