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MOUNT HOLLY TOWNSHIP SCHOOLS

MEDICATION FORM

To be completed by a PHYSICIAN:

Name of student _____ Grade _____

Medication _____

Dose, time and route _____

Purpose _____

For school trips – omit that dose: _____ yes _____ no

Physician signature _____

Physician name/stamp _____

Address _____

Phone _____ Date _____

To be completed by PARENT/GUARDIAN:
I request that the above medication, in its original container, be administered to my child. I release the Mount Holly School Board and personnel from all liability. I give the School Nurse permission to contact the Physician and/or Pharmacist with any questions concerning the medication.

Signature of Parent/Guardian _____

Date _____

MEDICATION MUST BE IN ORIGINAL CONTAINER TO BE DISPENSED IN SCHOOL

ALL UNUSED MEDICATION MUST BE PICKED UP AT THE END OF THE SCHOOL YEAR BY THE PARENT

Medication will be discarded if not picked up by the last day of school.