

SCHOOL DISTRICT OF SPRINGFIELD TOWNSHIP
Montgomery County, Pennsylvania

PARENTAL MEDICATION CONSENT FORM
SCHOOL YEAR 20__/__

To: _____
Principal/School Nurse

I, _____, request that school personnel administer this prescribed
Please print parent guardian's name

medication to _____ according to the attached directions from his/her attending
Please print student's name

physician, _____.
Please print physician's name

Name of Drug: _____

Dosage: _____

Time to be Given: _____

Reason/Medical Condition: _____

Date

Parent/Guardian Signature

SCHOOL DISTRICT OF SPRINGFIELD TOWNSHIP
Montgomery County, Pennsylvania

PHYSICIAN'S MEDICATION ORDER FORM
SCHOOL YEAR 20__/__

To: _____

My patient, _____, is being treated for _____.

It is necessary that he/she receive this medication during school hours according to the following directions:

Name of Medication: _____

Dosage: _____

Time to be Administered: _____

Length of time to be given: _____

Possible Side Effects: _____

Date

Telephone

Physician's Signature

Erdenheim Fax 215-233-6094
Enfield Fax 215-233-4688

Middle School Fax 215-233-6091
High School Fax 215-233-0691