

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

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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