



STERLING HIGH SCHOOL

HOME OF THE SILVER KNIGHTS

Elizabeth Donato, RN, BSN

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TO: SCHOOL NURSE

FROM: DR. _____ PHONE #: _____

ADDRESS _____

RE: STUDENT NAME: _____

This student is under my medical care. His/Her treatment requires dispensing medication as stated below.

Please allow this patient to adhere as closely to his/her medication schedule as possible. He/She must take the medication in the school health office.

DIAGNOSIS _____

SPECIFIC INSTRUCTIONS _____

MEDICATION _____ DOSAGE _____

PRECAUTIONS/SIDE EFFECTS _____

DOCTOR'S SIGNATURE

DATE

As parent/guardian of _____, a student in Sterling High School, I hereby request school authorities to allow my child to take medication during school hours as prescribed by Dr. _____.

I understand the medication will be brought to school with written permission on the original container.

PARENT/GUARDIAN SIGNATURE

DATE