

**PENNS GROVE—CARNEYS POINT REGIONAL SCHOOL DISTRICT**

**MEDICATION PERMISSION FOR  
MEDICATION AND/OR TREATMENT**

**PHYSICIAN WRITTEN ORDER: (Include name of medication, dose, route,  
frequency, diagnosis)**

**SCHOOL**\_\_\_\_\_ **GRADE**\_\_\_\_\_

**STUDENT**\_\_\_\_\_ **CLASS**\_\_\_\_\_

**WRITTEN PERMISSION OF PARENT OR GUARDIAN:**

\_\_\_\_\_  
**Parent/Guardian Signature/Date**

\_\_\_\_\_  
**School Nurse Signature/Date**