South Brunswick Township Public Schools

Medication Order - Physician/Dentist/Parent

School:_____ Date:_____

PART I - TO BE COMPLETED IN FULL BY THE STUDENT'S PHYSICIAN OR DENTIST

I certify that it is essential to the health of _____ that the following medication be administered during school hours as directed.

TEACHER:_____ GRADE: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

MODE OF ADMINISTRATION: _____

TIME OF ADMINISTRATION: _____

FREQUENCY OF ADMINISTRATION: _____

SIDE EFFECTS, IF ANY: _____

LENGTH OF TIME ORDER IS VALID: _____
(may not exceed school year)

MEDICATION INFORMATION/ ADJUSTMENTS

If this medication is to be given on a regular basis, please indicate what needs to be done when the student is on a class trip or on early closing days. Teaching staff cannot give medications.

Check one:

_____ Student will not be taking the medication on a class trip.

_____ Administer the medication when the student returns from the class trip.

_____ Parent will administer the medication when accompanying student on the class trip

Circle one: Administer / Do Not Administer the medication on early closing days.

Date _____ Signature of Physician/Dentist _____

Telephone Number _____

Physician/Dentist Stamp

PART II -TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I hereby request that the school nurse administer the medication as directed by my physician to my child _____. I will supply the medication in its ORIGINAL CONTAINER and will notify the school nurse promptly of any change.

_____

Signature of Parent/Guardian

_____

Date

Please list any medications taken at home:
(Include Name, Time and Reason)

_____

_____

_____

_____

Other Comments or Instructions:

_____

_____

_____

_____

Thank you for your help and cooperation.