WHITE TOWNSHIP CONSOLIDATED SCHOOL
565 County Road 519
Belvidere, NJ 07823
Phone: (908) 475-4773
Fax: (908) 475-3627

Physician's Orders for Medication at School
School Year _____

Student: _____Date of Birth: _____

Medication should be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the School Nurse, principal or other designated personnel will dispense the medication. The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

PRN MEDICATIONS given during regular school hours. (Please include OTC medications, such as Tylenol, Ibuprofen for headache, cramps, etc.)

Is it necessary to dispense this medication during school hours? _____Yes _____No
If yes, please give diagnosis or reason:
_____

Medication: _____

Dose and frequency: _____

Method of administration: _____

Side effects of drug (if any) to be expected: _____

Medication to be carried by student: _____Yes _____No (if yes – please fill out self-medication sheet)
***Please note self-medicate is for "potentially life threatening illnesses" only, such as bee sting allergy, asthma, diabetes and cystic fibrosis. No other medications are permitted to be carried and self-administered by students.*

Physician Signature: _____ Print or Stamp Name: _____

Date: _____ Phone: _____

Parent's Permission

* The medication to be furnished is to be brought in by me in the original container labeled by the pharmacy or physician with the child's name, name of the medicine, the amount to be taken, the time of day to be taken, and the physician's name.
* I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions.
* This authorization is good for the current school year only.
* In case of necessity, the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.
* I am the parent or legal guardian of the child named.

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____