Tuckerton Elementary School District

Mrs. Janet Gangemi
Superintendent/SBA

Mrs. Siobhan Grayson
Principal

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Healthcare Provider's Order

Student Name________________________________Diagnosis___________________________

Medication____________________________Dosage_____________________________________

Frequency or time of day to be given at school____

If medicine is to be given *when needed*, please describe conditions________________________________

____

Please list any significant side effects:____

Length of time this treatment is to continue (no longer than one school year)_____________________

Known allergies/other information____

It is my understanding that the school nurse of Tuckerton Elementary School charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alterations from the above will occur only with written directions from the attending physician.

Please indicate below whether the above named student may or may not have his/her daily medication suspended for a field trip. Please understand that efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs are in attendance. The district cannot always guarantee the availability of a substitute nurse. A parent or guardian may accompany the student on a field trip for the purpose of administering medication.

_____YES _____NO This drug may be omitted on half days and field trips.

____

Physician's Name (PRINT) Physician's Signature (*Stamped signature NOT acceptable*) DATE

PO Box 217, Marine Street, Tuckerton, NJ 08087 - Fax # 609-296-1480

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Parent/Guardian Permission

Student Name______________________________________ D.O.B:____/____/____

____

Physician's Name | Physician's Phone Number

We/I request that my child be assisted by the school nurse in taking medication(s) as prescribed by my child's physician. We/I will indemnify and hold harmless the district and any and all employees of the district against any injury or claims that arise as a result of the nurse's administration of my child's medication. We/I realize that We/I must renew this certificate annually. We/I also give the school nurse permission to contact the physician below with regards to matters concerning our/my child's medication or condition. We/I understand that the school district and its employees and agents shall incur no liability as a result of any injury arising from the administration of medications, including epi-pen, of our/my child. We/I further understand that we/I hereby indemnify and hold harmless the school district and its employees and agents against any injury or claims arising out of the nurse's administration of our/my child's medications, including the administration of epi-pen by the school nurse or the individual designated by the school nurse who shall be permitted to administer epi-pen to our/my child when the nurse is not physically present at the scene.

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Date | Parent/Guardian's Signature | Home Phone # | Work/Emergency #

____

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