AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY THE SCHOOL NURSE

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

Child's Name: ____________________________ Child's 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: ____

Please note, if a child has a potentially life threatening condition, the Self-Medication Dispensing Form must be completed and signed by both the ordering physician and the parent prior to the student being allowed to carry his/her medication. Contact the school nurse for the appropriate form.

It is my understanding that the school nurses of Berlin Township 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.

In addition, 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.**

__________ **YES** __________ **NO** **This drug may be omitted on field trips.**

____

Physician's Name (Print) Physician's Signature (Stamped signature is not acceptable) Date

(OVER)

THE FOLLOWING IS TO BE COMPLETED BY THE PARENTS/GUARDIANS:

Child's Name:____ Birth Date:______________

Last First

____

Physician's Name Address Phone Number

I request that my child be assisted by the school nurse in taking medication as prescribed by my child's physician. I will indemnify and hold blameless the District and any and all employees of the District against any injury or claims that arise as a result of the nurses' administration of my child's medication. I realize that I must renew this certificate annually. I also give the school nurse permission to contact the physician who wrote this medication order with regards to matters concerning my child's medication or condition. 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 epinephrine via auto-injector or glucagon, of my child. I further understand that 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 my child's medications, including the administration of epinephrine via auto-injector or glucagon by the school nurse or by the individual(s) designated by the Board of Education who shall be permitted to administer epinephrine via auto-injector or glucagon to my child when the nurse is not physically present at the scene. I further understand that the individual(s) designated by the Board of Education will be trained according to the procedures specified in the "Training Protocols For The Emergency Administration of Epinephrine, dated September 2008" to give epinephrine via an auto-injector or "Care of the Student with Diabetes in New Jersey's Public Schools" to give glucagon.

I understand that all medication shall be brought to school by parent/guardian and shall be picked up at the end of the school year or the end of the period of medication, whichever is earlier.

I understand that if my child will need/or has the potential to receive this medication while on a school trip that I may accompany my child on the field trip. If I am not able to attend the field trip I understand that the school district will attempt to employ a substitute school nurse for the 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. I understand that the district cannot always guarantee the availability of a substitute nurse.

Name of medication: ____

____

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

AUTHORIZE PERMISSION TO SPEAK WITH HEALTHCARE PROVIDER

I authorize the sharing of medical information about my child, _______________________, between my child's physician or advanced practice nurse and other health care providers in the school.

Signature____Date_________

Parent/Guardian