

Island Heights School District Health Services

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**Physician Orders for Medication Administration in School**

Student's Name: \_\_\_\_\_ Birth date \_\_\_\_\_

Parent/Caregiver's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone – Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**PART 1: TO BE COMPLETED BY STUDENT'S PHYSICIAN OR DENTIST**

***PLEASE COMPLETE ALL SECTIONS THAT APPLY*** (one medication per consent form)

**A. MEDICATION ORDERS:**

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Mode of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Time of Administration: \_\_\_\_\_

Side Effects/Precautions: \_\_\_\_\_

Length of time order is valid \_\_\_\_\_

**B. MEDICATION SCHEDULE ADJUSTMENTS:**

If medication is to be given on a regular basis, please instruct below for special circumstances. Teaching staff will not give medication on class trips and students may not self-administer any medication except those for "life-threatening conditions" (N.J.S.A. 18A:40 – 12.3.)

\_\_\_\_\_ Medication may be omitted on class trip.

\_\_\_\_\_ Administer the medication when the student returns from class trip.

- CIRCLE ONE: Administer / Do Not Administer medication on *early closing* days.
- CIRCLE ONE: Administer / Do Not Administer medication on *delayed opening* days.

Healthcare provider/stamp:

Health care provider signature \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*\*Please see other side for more information and signatures.\*\*\***

PART 2: TO BE COMPLETED BY PARENT/CAREGIVER

A. PARENT/CAREGIVER PERMISSION FOR SCHOOL NURSE ADMINISTRATION OF MEDICATION

**To be completed by Parent/Caregiver:**

I give permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required. The prescribed medication will be provided by me in the original container with the appropriate pharmacy label and kept in the nurse office.

I shall indemnify and hold harmless the Island Heights School District and its employees or agents for legal fees, costs, and any potential damages concerning the use of the medication arising out of any claims brought by the above named child or anyone else.

**I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.**

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**Parent/Guardian signature**

**Date**