Gloucester City Public School District

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Students requiring medication administration during school hours must have the following information supplied to the school nurse.

1. A doctors written instruction including medication name, dosage, time, and duration of administration and if it is to be given on an "as needed basis", a list of indications for use.
2. Parental signed consent
3. The medication in the original container with a prescription label or the "over the counter" label

Name of Student:_____ **Date of Birth:** _____
School/Homeroom: _____

*TO BE COMPLETED BY PHYSICIAN

Medication/ dosage: _____
Time(s):_____ **Route:** _____
(Please include A.M. dose and time if it is permissible for school nurse to administer a forgotten home A.M. dose. The missed dose must be confirmed by parent)
Indication for use: _____
Possible side effects: _____
Are there any restrictions, if yes please describe: _____
Student __May, ___May Not, miss a dose of medication to attend a field trip or special activity.
May self administer inhaler on school approved trips: ___ yes, ___no

_____ _____
Printed name of physician **Date**

***FOR SELF ADMINISTRATION ONLY**
Self administration of medication may be performed by pupils with a potentially life threatening illness, namely asthma or severe allergic responses. The above named pupil is capable of and has been instructed on the proper technique of self-administration. The pupil is physically fit to attend school.

***TO BE COMPLETED BY PARENT/GUARDIAN**
I,_____, give permission for my child to receive the above medication as directed by his/her physician. My child may self-medicate for asthmas ordered by his/her physician.

I, _____, give permission for my child to receive Tylenol, Ibuprofen or Tums as needed during the school day from the school nurse.

Signature: _____ Date: _____

Emergency Contact Name: _____ Phone Number: _____