HADDDON HEIGHTS ELEMENTARY SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY THE SCHOOL NURSE

The following is to be completed by the **Parents/Guardians:** School: _____

Child's Name: _____ Sex: _____ Birth Date: ____/____/____
Last First MI

_____
Physician's Name Address Phone Number

We/I request that my child be assisted by the school nurse in taking medication(s) as prescribed below by my child's physician. We/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 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 of our/my child. We/I further understand 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.

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

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

THE FOLLOWING IS TO 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 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 Haddon Heights 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.

For the emergency administration of epinephrine for anaphylaxis, this form may be signed by either the physician or advanced practice nurse. In that case, the student named above requires the administration of epinephrine for anaphylaxis and does not have the capability for self-administration of the medication.

_____ _____ _____
Physician's Name (Print) Physician's Signature (stamped signature is **NOT** acceptable) Date
Office Stamp: