BERNARDS TOWNSHIP PUBLIC SCHOOLS
MEDICATION ORDER FORM

For completion by parent/guardian:

Name of Student_____ Date of Birth_____

Name of School _____ Grade_____ Teacher_____

Allergies (Insect Sting /Food / Medication)_____

I hereby request and authorize appropriate Bernards Township Public School employees to administer prescribed medication as directed by the undersigned licensed health care provider. I grant permission for Bernards Township Public School employees to exchange information with my child's health care provider as deemed necessary. **I have read the guidelines on the reverse of this form and assume the responsibilities as required.**

Parent/Guardian Signature _____ Date_____

For completion by Physician/Advanced Practice Nurse:

Diagnosis_____Medication_____Dosage_____Route_____

Frequency: Daily_____ (indicate time of administration)_____

PRN_____ (indicate signs/symptoms requiring administration)_____

Side effects of medication_____

Restrictions on Daily Activities_____

Medication administration to begin on _____/_____/_____ and discontinue on _____/_____/_____.

I certify that this child would be unable to attend school if this medication is not administered during school hours and that this student is physically fit and able to attend school. _____ Yes_____ No

INHALER FOR SELF-ADMINISTRATION:

I have instructed this child in the proper administration of this medication and certify that he / she is capable of self-administering this medication ____YES ____NO

As per Bernards Township Board of Education Policy 5330, permission for administration of medication in school or at school related events will be given only when the pupil's attendance depends upon the timely administration of medication in school or at school related events.
We strongly encourage that any medication that can be taken before or after school be so prescribed.

_____

Physician Signature **Date**

PHYSICIAN STAMP
(MUST BE PRESENT FOR ORDER TO BE VALID)

_____

Telephone Number

This medication order is valid for the school year

School Nurse Signature _____Date order in effect_____