GREATER EGG HARBOR REGIONAL HIGH SCHOOL DISTRICT

PERMISSION TO ADMINISTER MEDICATION

Dear Parent/Guardian and Doctor:

It is preferred that any medication, whether prescription or non-prescription, be given before or after school hours whenever possible. However, if it is essential that a student receive medication during school hours we will need you to provide the following information. The form is valid for the current school year only.

Thank you for your cooperation.

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TO BE COMPLETED BY PHYSICIAN

Student's name_____DOB_____

Medical diagnosis_____

Name of medication_____

Dosage_____Route_____

Time_____Frequency_____

List indications for use_____

Side Effects_____

Duration of order_____

List other medications student is on which may enhance, alter, or impact this medication

_____

This student needs to "participate as tolerated" in physical education- Yes_____No_____

List any other limitations or comments

_____

Physician's signature_____Date_____

Physician's phone number_____

TO BE COMPLETED BY PARENT/GUARDIAN

ADMINISTRATION OF MEDICATION BY THE SCHOOL NURSE

I request and grant permission for the school nurse to administer medication to my child, _____ as prescribed by his/her physician as indicated on the reverse side of this form and as per the policy of the Greater Egg Harbor Regional High School District Board of Education and State Law. I understand that any oral medication is to be brought to school by myself in the original prescription container labeled properly by the physician or pharmacist.

Parent/Guardian Signature_____Date_____

Phone Number_____