LINDENWOLD PUBLIC SCHOOLS HEALTH OFFICE

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY THE SCHOOL NURSE

The following is to be comp	School: Lindenwold School					
Child's Name:	Sex:	Birth Date:	/ /			
Last	First	MI				
Physician's Name Addre		Addres	S		Phone Number	_
I request that my child be as indemnify and hold blamele the nurses' administration of permission to contact the ph the school district and its emmedications to my child.	ss the District and any and my child's medication. It ysician below with regard	d all employee I realize that I i ds to matters co	s of the Distric must renew this oncerning my o	ct against any injui s certificate annua child's medication	ry or claims that arise ally. I also give the so or condition. I under	as a result of chool nurse rstand that
Date Parents/Guardian's S		ture	Home	Phone #	Work/Emergency #	-
THE FOLLOWING IS						
Child's Name:		Child	Child's Diagnosis:		_	
Medication:		Dosage:		_		
Frequency or time of day to	be given at school:					_
If medicine is to be given wh	hen needed, please describ	be conditions:				_
Please list any significant sig	de effects:					_
Length of time this treatmen	t is to continue (no longe	r than one scho	ool year)			_
Known allergies/other inform	nation:					

Please note, if a child has a 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 Lindenwold 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.

In addition, please indicate below whether the above-named student may or may not have his/her daily medication suspended for a field trip. Please understand that efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs are in attendance. The district cannot always guarantee the availability of a substitute nurse. A parent or guardian may accompany the student on a field trip for the purpose of administering medication.

YESNO	This medication may be omitted on half days and field trips.			
DL				
Physician's name (PLEASE PRINT)	Physician's signature (Stamped signature not acceptable)			
Address	Phone number			
	Date			