SOUTH HARRISON TOWNSHIP SCHOOL DISTRICT
Medication Dispensing Form

The student listed below is under my medical care. His/her treatment requires dispensing medication during school hours as stated below:

Student's Name _____

Reason for Medication_____

Name of Medication _____ Prescription ( )
Non-Prescription ( )

Dosage_____ Time to be administered_____

Effective dates from _____ to _____

Route of Administration _____

Specific Istructions_____

Precautions / Side Effects _____

It is my understanding that the school nurse, 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.

Date _____ Physician's signature _____

Address _____

Telephone _____

Parental Permission

Medication has been prescribed for my child, _____. As parent/guardian, I hereby request the administration of the medication described above to my child and release the South Harrison Township School District and its employees of any responsibility or liability in giving this medication. I understand the medication brought to school must be labeled and in the original container. I also understand that if the nurse or I are unable to accompany my child on school trips, the medication will not be given.*

Date _____ Signature of Parent / Guardian _____

____ I give my permission for the SHTES nurse to speak with my child's physician.

*** NB: NJ JERSEY STATE LAW ALLOWS CHILDREN TO SELF-MEDICATE FOR LIFETHREATENING CONDITIONS ONLY. YOUR PHYSICIAN MUST CERTIFY IN WRITING, THAT THE PUPIL, THE PARENT/GUARDIAN, OR DESIGNATED ADULT IS CAPABLE OF ADMINISTRATING THE MEDICATION. IF A CHILD IS ALLOWED TO SELF-MEDICATE, OUR SCHOOL WILL ALLOW THEM TO DO SO UNDER THE SUPERVISON OF A DESIGNATED ADULT. CONTACT YOUR SCHOOL NURSE FOR THE "Emergency Medication on Field Trips" FORM.**