Community Charter School *of* Paterson

IN-SCHOOL MEDICATION CONSENT FORM

(for all medications **except** anaphylaxis meds such as Benadryl, epi-pens, and asthma inhalers)

Student's Name: _____ DOB _____ Grade: _____

Parent/Guardian's Name: _____ Date: _____

Home Phone: _____ Cell: _____

FOR THE PHYSICIAN: Medication Orders

I certify that it is essential to the health of _____ that the following medication be administered by the school nurse during school hours as directed. Valid only for school year.

Name of Medication: _____ Dosage _____

Mode of administration: _____ Time of administration: _____

Frequency of administration: _____ Length of time order is valid _____

Diagnosis: _____ Side Effects/Precautions: _____

A. MEDICATION SCHEDULE ADJUSTMENTS:

If medication is to be given on a regular basis, please instruct below for special circumstances. Teaching staff will not give medication on class trips and students may not self –administer any medications except for those for "Life-threatening conditions" (N.J.S.A. 18A:40- 12.3)

_____ Medication may be omitted on a class trip.

_____ Administer the medication when the student returns from the class trip.

_____ Parent will administer the medication to his/her child while accompanying the class trip

Circle one: **Administer/ Do not administer** medication on early closing days.

Circle one: **Administer/ Do not administer** medication on delayed opening days.

FOR PHYSICIAN	FOR PARENT/GUARDIAN
Office Stamp:	I give permission for the school nurse to administer the medication described above. I will notify the nurse immediately if this medication is no longer required. I understand that the permission to give this medication is effective for the school year for which it was granted and must be renewed for each subsequent school year.
_____ _____ Physician Signature Date	_____ _____ Parent/ Guardian Signature Date

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