

**STUDENT MEDICATION FORM**

**STUDENT INFORMATION:**

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

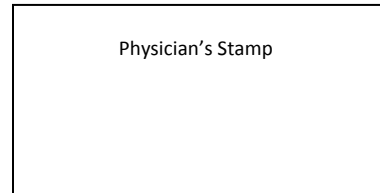
Parent/Guardian Phone: \_\_\_\_\_ home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

**MEDICAL PROVIDER INFORMATION:**

Licensed Medical Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



**MEDICATION INFORMATION TO BE COMPLETED BY PHYSICIAN:**

DOCTOR'S REQUEST/INSTRUCTIONS FOR STUDENT \_\_\_\_\_ Start Date: \_\_\_\_\_

**SELF ADMINISTRATION OF MEDICATIONS FOR POTENTIALLY LIFE THREATENING ILLNESS**

The Medication listed below is to be self administered by my patient \_\_\_\_\_  
STUDENT'S NAME

I hereby certify that my patient has a life threatening illness and that my patient is capable of and have been instructed in the proper administration of the required medication.

MEDICATION: \_\_\_\_\_ DOSE/ ROUTE: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature \_\_\_\_\_ Print Physician's Name \_\_\_\_\_ Date \_\_\_\_\_

**ADMINISTRATION OF MEDICATION BY SCHOOL NURSE**

The Medication listed below is to be administered to my patient \_\_\_\_\_  
STUDENT'S NAME

Medication: \_\_\_\_\_ Dose & Route: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Treatment to be continued until: \_\_\_\_\_

Significant Side Effects : \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Print Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

**PARENT REQUEST AND RELEASE TO BE COMPLETED BY PARENT/GUARDIAN**

I request my child \_\_\_\_\_ to receive/self administer the medication designated above. I have been informed by the school district, its agents, servants, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the Secaucus Board of Education, its agents, servants, and employees from any and all claims, and shall defend any lawsuit that may arise out of or in connection with the administration of medication by my child.

\_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Print Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

**All medications must be in the original container appropriately labeled by the pharmacy or medical provider.**