Delsea Middle School Health Office
Marc Haro, RN, BSN
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Administration of Medication

Name of Student:_____ _____ _____
Last First MI

Grade _____ Sex_____ Date of Birth_____

Medical Condition being treated:

Diagnosis:_____

Medication: _____ Dosage:_____ Time:_____

How soon can it be repeated: _____

Is student authorized to self medicate (life threatening conditions only): _____

Significant side effects/adverse reactions:_____

Special instructions if side effects occur:_____

How long is medication to be given (days, months, school year) : _____

To be given on half days? Yes__ No __ To be given on field trips? Yes__ No __

Medical Professional Authorization

I certify that the above information is true and correct. The student is physically fit to attend school and is free of contagious disease. If the condition is life-threatening, I further certify that the student is capable of and has been instructed in the proper method of self medication.

_____ _____

Physician, Dentist, APN (PRINT) Physician, Dentist, APN signature

_____ _____

Office Phone Number Date

Parent/Guardian's Authorization for Medication or Self-Medication

I give permission for my child to receive from the School Nurse or to self-administer the above medication as directed by our family medical provider. This authorization is for this school year only and must be renewed for each subsequent school year. I agree to release Delsea Regional School District, their employees and agents from any and all liability that may result from the self administration of a medication by the student.

_____ _____ _____

Date Parent/Guardian Signature Phone (during school hours)