

Wallington Public School
Wallington, New Jersey

School Year _____

Student Medication Form

I. PHYSICIAN'S ORDER OF MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE

The following medication is to be administered to my Patient: _____

Diagnosis _____

Medication/Dosage _____ Time of administration _____

Length of Treatment _____

Possible Side Effects _____

Physician Name (Stamp)

Physician Signature

Date

II. PARENT/GUARDIAN REQUEST AND RELEASE

I request for my child, _____, to receive the medication above as directed by my physician. I have been informed that the school district, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child. I will provide properly labeled medication to the health office. I hereby indemnify and hold harmless the Wallington Board of Education, its agents, and employees from any and all claims.

III. FIELD TRIP ORDERS

Please be advised that the School Nurse does not always accompany classes on field trips. Medication cannot be administered by teachers or other school personnel. Please have your physician check the appropriate action:

_____ The above student **does not** need to take prescribed medication on the day of the field trip.

_____ The above student **does** need to take the prescribed medication on the day of the field trip.

Parent Signature

Physician Signature

Physician Stamp