IN-SCHOOL MEDICATION CONSENT FORM

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

Student Name: _____ DOB: _____

Parent/Guardian's Name: _____ Date: _____

Home Phone: _____ Cell: _____

FOR THE PHYSICIAN: **[Parent/Guardian must sign at the bottom.]**

A. **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.

Diagnosis: _____

Name of Medication: _____

Dosage: _____ Mode of Administration: _____

Frequency of Administration: _____ Time of Administration: _____

Side Effects/Precautions: _____

Length of time order is valid (may not exceed school year): _____

B. **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 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: _____ _____ Physician/Dentist signature Date	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 disclaim all liability of Abundant Life Academy as it concerns the use of this medication. I further understand that the permission to give this medication is effective for the school year for which it is granted and must be renewed for each subsequent school year. _____ _____ Parent/Guardian Signature Date