Margaret Gibson RN, BSN, CMSRN- x205 Heather Pach RN, BSN, CMSRN- x255

**Berlin Community School**

Office of the Nurse

215 Franklin Avenue

Berlin, NJ 08009

Phone: 856-767-0129

Fax: 856-768-6853

Dear Parent/Guardian:

If your child will need to receive medication at school, please read the following information. State law requires that Doctor’s orders and parent permission are in place for a child to receive medication at school. **Medication orders must be re-written each school year**.

Please bring the completed forms to the health office along with the medication. Forms are available on our **website**. For safety reasons, students are not permitted to transport medications to and from school. The medication must be in the original container, labeled by the pharmacy. For nebulizer treatments, please supply the medication, tubing, and the mouthpiece or mask.

**Over the counter medications** also **need doctor’s orders** and **parent permission**. Over the counter medications must be in a new, unopened container for safety reasons. Open bottles will not be accepted.

Please note: The doctor and parent/guardian must sign twice if the student has permission to self –medicate with asthma inhalers or Epi-pens.

Thank you for your assistance. Please contact the Nurse’s office at 856-767-0129 x205/x255

Respectfully,

Margaret Gibson, RN, BSN, CMSRN Heather Pach, RN, BSN, CMSRN

**BERLIN COMMUNITY SCHOOL MEDICATION DISPENSING FORM**

**PARENTAL AUTHORIZATION**

School Year\_\_\_\_\_\_\_\_\_

I request the enclosed medication, in the original container, be administered to my child and shall release school personnel from all liability. I give the School Nurse permission to contact the physician and/or pharmacist with any questions concerning the medication.

**Name of Child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and Strength of Medication:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dosage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We, the parents or guardians, of the student acknowledge that the district shall incur no liability as a result of any injury arising from the self administration of medication by the student and that we shall hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student. The permission is effective for the school year for which it is granted.

**Signature of Parent/Guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* In case of Asthma or potentially life threatening illness, will the student be self-medicating? YES\_\_\_NO\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Is the student permitted to self medicate on class trips? YES\_\_\_ NO\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*In regard to specific food allergies, does your child require the classroom to be “FREE” of this specific food? YES\_\_\_ NO\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*In regard to specific food allergies, does your child require an “allergy free” table in the cafeteria? YES\_\_\_ NO\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BERLIN COMMUNITY SCHOOL DOCTOR’S AUTHORIZATION**

School Year\_\_\_\_\_\_\_\_\_

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name & Strength:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: (in mg, not liquid measure) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time, Frequency and Route of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Effective Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most Common Side Effects:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is my understanding the School Nurse charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Doctor’s Phone # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Stamp:

|  |
| --- |

I certify that the pupil has asthma or another life threatening illness and is capable of, and has been instructed in the proper method of self administration of medication. In case of Asthma or potentially life threatening illness, will the student be giving himself/herself this medication? YES NO If yes, please sign below.

Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_