LENAPE REGIONAL HIGH SCHOOL DISTRICT MEDICATION FORM

CHEROKEE 856-983-5140 Fax: 856-810-4379 (grades 9 & 10) Fax: 856-810-4378 (grades 11 & 12)	LENAPE 609-654-5111 Fax: 609-714-7808	SENECA 609-268-4600 Fax: 609-268-4389	SEQUOIA 609-268-3700 Fax: 856-983-5143	SHAWNEE 609-654-7544 Fax: 609-714-3009

To be completed by the PHYSICIAN: For all prescription/non-prescription medications except Asthma and Diabetes medications and Benadryl/Epinephrine (see separate forms on website). One form per medication.

These orders remain in effect during the school day, school sponsored activities, and school sponsored overnight trips.

_____ is to receive _____ _____
STUDENT'S NAME MEDICATION DOSE

_____ for the treatments of _____
DOSING FREQUENCY

POSSIBLE SIDE EFFECTS/COMMENTS_____

_____

HOW LONG THIS IS TO BE GIVEN_____

PHYSICIAN'S SIGNATURE_____

PHYSICIAN'S NAME/STAMP_____

ADDRESS_____

PHONE_____ DATE_____

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To be completed by the PARENT/GUARDIAN:

I request that the above medication, in the original container, be administered to my child. I acknowledge that the school district and its employees or agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and/or pharmacist with any question concerning the medication. I give my permission for relevant health information to be shared with teachers/staff.

PARENT'S/GUARDIAN'S SIGNATURE:_____

DATE:_____ STUDENT'S GRADE:_____

NOTE: Medication is to be supplied in the original container. Ask your pharmacist to divide the medication into two completely labeled containers – one for home and one for school.

Rev. 9/23