This page is to be completed by Parent/Guardian and Physician

Form 4

Black Horse Pike Regional School District -Medication – Dispensing Form

List only one medication on a form, additional forms available upon request.

Parent

PARENTS SHOULD FILL OUT THE BOLDED AREAS

I request the enclosed medication, in the original container, to 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 question concerning the medication.

Name of Child _____

Name & Strength of Medication _____

Dosage _____

Signature of Parent/Guardian *X* _____

INHALER AND EPI-PEN PATIENTS ONLY

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

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

Signature of Parent/Guardian *X* _____**Date**_____

Both sections must have completed information and required signatures.

Doctor

DOCTORS MUST COMPLETE ALL BOLDED INFORMATION

Students Name _____ **Age** ____ **Grade** ____ **School** _____

Name & Strength of Medication _____**Dosage** _____

Time & Route of Administration in School _____

Reason for Medication _____

Effective Dates: from_____ **to** _____

Most common side effects: _____

It is my understanding the School Nurse charged with the administration of medication may rely upon my direction 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.

_____ ***X*** _____

Doctor's Name (Print) **Doctor's Signature**

_____ _____

Patient's Medication Allergies **Doctor's Address**

_____ _____

Date **Doctor's Telephone Number**

INHALER AND EPI-PEN PATIENTS ONLY

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 ***X*** _____

Doctor's Signature REQUIRED