**Eastampton Community School**
1 Student drive, Eastampton, NJ 08060
Phone: 609-267-9172
Fax: 609-261-3338

# GENERAL MEDICATION ORDERS

Place Child's Picture Here

**Student's Name:** _____

D.O.B. _____ Grade _____ Teacher: _____

Allergies: _____

DIAGNOSIS (purpose of medication): _____

**MEDICATION *:** _____

**DOSE and ROUTE:** _____

**FREQUENCY (days and times):** _____

ADDITIONAL INSTRUCTIONS: _____

_____

_____

* An Asthma Action Plan is required when prescribing inhaled medications.
* An Allergy Action Plan is required when prescribing epinephrine.
* An Seizure Action Plan is required when prescribing anti-seizure medications.

May this medication be omitted on field trips? _____ Yes _____ No

- ✓ This form is requested for both prescribed and over-the-counter medications.
- ✓ Orders need to be renewed each school year.
- ✓ Medications are to be stored in the nurse's office. Students are not permitted to carry them.
- ✓ Medications should be dropped off and picked up at school by a parent or other adult.
- ✓ Medications should be supplied in their original packaging. Prescriptions should include the pharmacy label.

I hereby give permission for my child to receive medication at school as prescribed above. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with the school staff on a need to know basis.

**Parent/Guardian's Signature** _____ **Date** _____

**Parent/Guardian Print Name** _____

**Physician's Signature** _____ **Date** _____

**Physician Print Name** _____

**Physician's Phone Number** _____

***(Physician's Stamp)***