ESCUELAS PÚBLICAS DE LINDENWOLD
OFICINA DE SALUD

AUTORIZACIÓN PARA LA ADMINISTRACIÓN DE MEDICINAS POR LA ENFERMERA DE LA ESCUELA

Lo siguiente deberá ser completado por los **Padres/Tutores**: Escuela: Lindenwold School #

Nombre de Estudiante: ______________________________ Sexo: ______ Fecha Nacimiento:_____/_____/_____
Apellido Primer Nombre Inicial

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Nombre de su Médico Dirección Número Teléfono

Solicito que mi hijo(a) sea asistido(a) por la enfermera de la escuela para que tome su(s) medicamento(s), según receta anotada a continuación por su médico. Garantizo que mantendré libre de culpa al Distrito y a todos sus empleados de cualquier daño o reclamo que surja como resultado de la administración por las enfermeras del medicamento de mi hijo(a). Comprendo que debo renovar este certificado anualmente. También doy permiso a la enfermera de su escuela para ponerse en contacto con el médico cuyo nombre aparece a continuación con respecto a asuntos relacionados con los medicamentos o la condición de mi hijo(a). Entiendo que el distrito escolar y sus empleados y agentes no serán responsables de ningún daño que pueda derivar de la administración de dicho(s) medicamento(s) a mi hijo(a).

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Fecha Firma de Padres/Tutores Teléfono Casa Teléfono Emergencia

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THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

Child's Name: ______________________ Child's Diagnosis: ______________________

Medication: ______________________ Dosage: ______________________

Frequency or time of day to be given at school: ______________________

If medicine is to be given *when needed,* please describe conditions: ______________________

____

____

Please list any significant side effects: ______________________

Length of time this treatment is to continue (no longer than one school year) ______________________

Known allergies/other information: ______________________

Please note, if a child has a potentially life threatening condition, the Self-Medication Dispensing Form must be completed and signed by both the ordering physician and the parent prior to the student being allowed to carry his/her medication. Contact the school nurse for the appropriate form.

-OVER-

It is my understanding that the school nurses of Lindenwold 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 alterations from the above will occur only with written directions from the attending physician.

For the emergency administration of epinephrine for anaphylaxis, this form may be signed by either the physician or advanced practice nurse. In that case, the student named above requires the administration of epinephrine for anaphylaxis and does not have the capability for self-administration of the medication.

In addition, please indicate below whether the above-named student may or may not have his/her daily medication suspended for a field trip. Please understand that efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs are in attendance. The district cannot always guarantee the availability of a substitute nurse. A parent or guardian may accompany the student on a field trip for the purpose of administering medication.

__________ YES __________ NO This medication may be omitted on half days and field trips.

____ ____

Physician's name (PLEASE PRINT) Physician's signature (Stamped signature not acceptable)

____ ____

Address Phone number

____ ____

Date