EASTERN CAMDEN COUNTY REGIONAL SCHOOL DISTRICT
Department of Student Health Services

IN SCHOOL MEDICATION FORM

Cathy D'Ascenzo, RN
11th - 12th
856-784-4441 x 1136

Michelle Filipkowski, RN
9th - 10th
856-784-4441 x 1250

To be completed by the PHYSICIAN:

________________________________ is to receive ______________________
(Student's Name) (Medication)
dosage at ____________________ for the treatment of ___________________
(Time)
Possible Side Effects/Comments:

____

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How long this is to be given: ____

______________________________ ______________________________
Physician's Signature Address

______________________________ ______________________________
Physician's Name/Stamp

______________________________ ______________________________
Date Phone Number

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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 and 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 questions concerning the medication.

__________________________________ ____________________________
Parent/Guardian Signature Date

NOTE: Medication is to be supplied in the original container. Ask your pharmacist to divide the medication into 2 completely labeled containers - one for home and one for school.