



Pineland Learning Center

Educating. Empowering. Transforming.

520 N. Fourth Street, Bldg. I • Vineland, N.J. 08360

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SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid for the current school year _____, including the Extended School Year (ESY) program.

This form must be completed in full by a Licensed Healthcare Provider (MD, DO, DMD, APN) for the school nurse to administer your child's medication during school hours. Each medication administered during school hours requires a separate form. A new School Medication Administration Authorization form must be provided at the beginning of each school year; and whenever there are any changes in dosage or time medication is to be administered.

- Prescription medication must be ordered by a Healthcare Provider and be in the original container with the original label intact.
- Non-prescription medication must be ordered by a Healthcare Provider and be in the original container.
- To transport medication to school, please contact school nurse.

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

Student Name: _____ DOB: _____ Grade: _____

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of administration: _____ If PRN, frequency: _____

Condition medication is being administered: _____

Relevant side effects: None expected: _____ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Physician's Name/Title: _____

Telephone: _____

Address: _____

Physician's Signature: _____ Date: _____



(USE FOR PHYSICIAN'S ADDRESS STAMP)

TO BE COMPLETED BY PARENT/GUARDIAN

I/We request designated school personnel to administer the medication as prescribed by the above physician. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be properly discarded. I/We authorize the school nurse to communicate with the physician as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Signature of school nurse who reviewed order: _____ Date: _____

Revised 8/2024

A progressive school empowering students who have challenges in learning, behaviors and social skills.

ACCREDITED BY THE MIDDLE STATES ASSOCIATION OF COLLEGES & SCHOOLS