

**EASTERN CAMDEN COUNTY REGIONAL SCHOOL DISTRICT
DEPARTMENT OF STUDENT HEALTH SERVICE**

IN SCHOOL MEDICATION FORM

Michelle Filipkowski, RN
9th & 10th grades
(856) 784-4441 x 1250

Christa Varga, RN
11th & 12th grades
(856) 784-4441 x 1136

To be completed by the PHYSICIAN:

_____ is to receive _____
(Student's Name) (Medication)

dosage at _____ for the treatment of _____
(Time)

Possible Side Effects/Comments: _____

How long this is to be given: _____

Physician's signature

Address

Physician's Name/Stamp

Date

Phone Number

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