PROCEDURES RE: STUDENTS RECEIVING PROPER MEDICATION AT SCHOOL

The following forms marked with an "A" in upper right corner are to be completed and returned to the school nurse if a student is to self-administer medications. The first form is completed by the child's physician and the second by the parent/guardian. The forms marked with a "B" in the upper right corner are to be completed by parent/guardian and the child's physician if our nurse is to administer medication to the child.

After the forms are completed, return to school nurse with the medication.

WATERFORD TOWNSHIP PUBLIC SCHOOLS

Atco Elementary	Thomas Richards	Waterford Elementary
Phone: (856)767-4200; Fax: (856)768-5497	Phone: (856)767-2421; Fax: (856) 753-1032	Phone: (856)767-8293; Fax (856)767-4159

Superintendent of Schools
Phone: (856) 767-4200; Fax: (856)768-5497

School Year: **2026 - 2027**

A-PHYSICIAN

WATERFORD TOWNSHIP PUBLIC SCHOOLS
PHYSICIAN'S CERTIFICATION

As a physician for_____, who attends_____ school, I hereby certify that this child has a potentially life-threatening condition which is _____ and this condition necessitates that he/she be permitted to self-administer a prescribed medication while in school or while attending a school sponsored trip or function.

This medication is: _____

Normal dosage/frequency: _____

Route of Administration: _____

Special Instructions: _____

Precautions/side effects: _____

Other medication student is taking: _____

I attest that the child has been instructed in the proper method[s] of self-administration of the above prescribed medication and is capable of doing same in a safe and appropriate manner.

_____ _____
Signature of Physician Date

_____ _____
Print Name of Physician Phone Number

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A- PARENT/GUARDIAN

WATERFORD TOWNSHIP PUBLIC SCHOOLS
PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION BY CHILD

To be completed by parent/guardian

I, _____, authorize the Waterford Township School District to permit my child, _____, who attends _____school, to self-administer medication which has been prescribed by my child's physician, _____. I attest that the need for my child's self-administration of medication is due to a potentially life-threatening illness. I further attest that my child has been instructed in the proper method[s] of self-administration of medication and is capable of safely conducting self-medication.

I understand and fully agree that the Waterford Township School District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration.

I further agree that the authorizations and acknowledgments made herein are effective for a full school year beginning September 1 through June 30, and said authorization shall also include the months of July and August following the school year if my child attends a district summer school. I also understand and agree that permission must be authorized each and every succeeding year through the completion of a new authorization form including a renewed physician's acknowledgement.

_____ _____
Signature of Parent/Guardian Date:

For School Year Beginning _____

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B-PHYSICIAN

WATERFORD TOWNSHIP PUBLIC SCHOOLS
MEDICATION DISPENSING AUTHORIZATION
PHYSICIAN'S AUTHORIZATION

The student listed below is under my medical care. His/her treatment requires dispensing medication during school hours as stated below:

STUDENT'S NAME _____SCHOOL_____

REASON FOR MEDICATION [DIAGNOSIS] _____

NAME OF MEDICATION _____
□Prescription □ Non Prescription
DOSAGE _____

TIME TO BE ADMINISTERED _____
ROUTE OF ADMINISTRATION _____
SPECIFIC INSTRUCTIONS _____
PRECAUTIONS/SIDE EFFECTS _____
OTHER MEDICATIONS STUDENT IS TAKING _____

_____ _____
Signature of Physician Date

_____ _____
Print Name of Physician Phone Number

B - PARENT/GUARDIAN

PARENTAL/GUARDIANSHIP PERMISSION

Medication has been prescribed for my child/ward _____.
As a parent/guardian I hereby request the administration of medication described medication described above to my child/ward and release the Waterford Township School District and its employees of any responsibility of liability in giving this medication. I understand that the medication must be in the original container and be properly labeled. I also understand that medication not picked up by the last day of school in June will be discarded.

_____ _____
Date Signature of Parent/Guardian