Gloucester County Institute of Technology
Medication Administration

Student's Name: _____ School Year: _____
Date of Birth: _____ Grade/Program: _____ Allergies: _____

*All medication, prescription and over the counter, ***MUST*** have a physician's order. *
*All forms must be renewed every school year and updated as needed with medication changes. *

Medications Taken IN SCHOOL:
All medication taken in school will be administered by a Nurse. Please have all prescription medications in the original pharmacy labeled container, and OTC medication in the original container. All medications must be brought to school by a parent/guardian.

Medications Taken ON TRIPS:
Students are allowed to *self-medicate* on trips. NJ State Law requires your doctor to sign this form if your student is taking a prescription or an over-the-counter medication on any trip, including Ibuprofen, Tylenol, birth control, etc. Please have all prescription medications in the original pharmacy labeled container, and OTC medication in the original container.

Medication	Dose/Route (mg/ml)	Time (specific or PRN)	Diagnosis/Purpose	**Physician Initials for Self-Administration**

Physician's Signature: _____ Date: _____ Physician's Stamp:
Physician's Printed Name: _____
Physician's Phone Number: _____

- If a student has asthma/inhaler, an **Asthma Treatment Plan** is required to be on file in the school nurse's office and student should carry their inhaler from home.
- If a student carries an EpiPen, an **Anaphylaxis Care Plan** is required to be on file in the school nurse's office and student should carry their epinephrine auto-injector from home.
- If a student has diabetes, a **Diabetes Care Plan** is required to be on file in the school nurse's office and the student must carry all diabetic supplies.

We, the parent/guardian of the pupil, acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil. We shall indemnify and hold harmless the district and its employees or agents against any claims arising out of self-administration of medication by the pupil. The permission is effective for the school year in which it is granted. I attest that my child is knowledgeable about his/her medication and may self-administer.

Parent/Guardian Signature: _____ Cell Phone: _____