GLOUCESTER CO. SPECIAL SERVICES SCHOOL DISTRICT
NONPUBLIC NURSING PROGRAM
1340 Tanyard Road
Sewell, NJ 08080
(856) 468-6530 x1045

FRIENDS SCHOOL
15 High Street
Mullica Hill, NJ 08062
(856) 478-2908
Fax (856) 478-0263

PHYSICIAN MEDICATION ORDER FORM
•SIGNED ORIGINAL ORDER REQUIRED•

Student's Name ______________________ Grade __________ DOB __________

Nonpublic School ____

*** PLEASE PROVIDE A SEPARATE FORM FOR EACH MEDICATION THAT IS TO BE ADMINISTERED.**

***PHYSICIAN TO COMPLETE:**

Diagnosis: ____

Medication: ______________________ DC Date: ______________

Dosage: __________ Route: __________ Time: ______________

Special Instructions: ____________________________________

Precautions/Side Effects: ________________________________

____

Date ____________ Physician Signature ______________________
(Original / No signature stamps please)

Physician Name ____
Address ____
Telephone No. ____

*** Please note: A Gloucester County Special Services School District (GCSSSD) nurse is not always available during school hours to administer this medication. Please contact the school principal to determine the manner in which medication will be dispensed in the absence of a GCSSSD nurse.**

*** A medication order is effective July 1 - June 30 of each school year and must be renewed annually.**

I give permission for (name of student) ______________________________

to receive medication at school as prescribed by Dr. ______________________

I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN THE ORIGINAL CONTAINER, PROPERLY LABELED, AND WILL PICK UP ANY UNUSED MEDICATION. (STUDENTS ARE NOT PERMITTED TO CARRY MEDICATIONS TO OR FROM SCHOOL.)

______________ ______________________________
Date Parent/Legal Guardian Signature

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GLOUCESTER COUNTY SPECIAL SERVICES SCHOOL DISTRICT
PERMISSION FOR EMERGENCY ADMINISTRATION OF EPINEPHRINE

THIS ORDER MUST BE RETURNED IN ITS **ORIGINAL FORM**. FAXES AND COPIES WILL **NOT BE ACCEPTED.**

I, the parent/guardian of ______________________ authorize my child, a pupil at ________________________
(Name of Student) (Nonpublic School)

School to be administered a pre-filled, single dose auto-injector mechanism containing epinephrine (provided by me) prescribed by our physician/or nurse practitioner as described below for anaphylaxis since he/she has a documented history of anaphylaxis and does not have the capability for self-administration of the medication. If the school nurse is not available, a designee will administer a pre-filled, single dose auto-injector mechanism containing epinephrine for anaphylaxis to my child. The designee has been properly trained by the school nurse using the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" established by the Department of Education in consultation with the Department of Health and Senior Services.

I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. **I further understand that neither the GCSSSD Board of Education, any district employee, chief school administrator of a nonpublic school, nor nonpublic school employee shall be responsible for any liability as a result of any injury arising from the procedures utilized for emergency administration of epinephrine to my child and that I shall indemnify and hold harmless the district or nonpublic school and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child.**

______________________________________ ______________________
Parent/Guardian Signature **Date**