SOUTH BERGEN JOINTURE COMMISSION

Medication/ Treatment Order Form

School Year _____

Student's Name: _____ **DOB:** _____

As _____, physician, I am prescribing the following medication(s) and requesting the school nurse to administer it.

Medication: _____ **Dosage:** _____ **Route:** _____**Time(s):** _____

Purpose: _____

Adverse Reaction: _____

Length of time for which medication is prescribed: _____

Administration Instructions: _____

_____
Physician's Signature

_____ _____
Date Print Name

PLEASE NOTE: **ALL** questions **MUST** be answered.

PARENTAL APPROVAL

The school nurse has my permission to administer the above medication to my son/daughter. I relieve the board and its employees of liability for administration of medication.

_____ _____
Date Signature of Parent/Guardian

PARENT: Please bring medication to the school in the original container, appropriately labeled by the pharmacy of the physician.