KEANSBURG SCHOOL DISTRICT
PUPIL PERSONNEL SERVICES
100 PALMER PLACE, KEANSBURG, NEW JERSEY 07734
732-787-2007 ext. 3300
732-495-7911 Fax

MEDICATION ORDER
– PHYSICIAN/DENTIST Authorization

I certify that it is essential to the health of _____ that the following medication be administered during school hours as directed:

Diagnosis: _____

Name of Medication: _____ Dosage: _____

Mode and time of administration: _____

Frequency of administration: _____

Side effects: _____

Student has been instructed and is able to self administer (inhalers only) : **YES** **NO**

Date: _____ Signature of Prescriber: _____

Office Stamp

To be completed by student's Parent/ Guardian

I hereby request that the school nurse administer the medication specified above as directed by my physician/dentist to my child _____. I will supply the medicine in an ORIGINAL CONTAINER and will notify the school nurse promptly of any changes in this order.

Date: _____ Signature of Parent/guardian _____

I verify that my son/daughter has my permission to self-administer the medication (fo: asthma) (***certification must be provided from student's physician acknowledging pupil has been instructed in the proper method of self-administration of medication)***

Date: _____ Signature of Parent/guardian _____

Waiver of Liability (*waiver must be signed by parent/guardian in order for administration of medication by nurse, designee or self-administration by pupil)*
I agree that if the procedures specified in Board Policy 5330 regarding administration of medication are followed, the school district and its employees or agents shall incur no liability as a result of any injury.

Date: _____ Signature of Parent/guardian _____