Tuckerton Elementary School District

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Healthcare Provider's Order

Student Name________________________________ Diagnosis___________________________

Medication____________________________ Dosage______________________________________

Frequency or time of day to be given at school____

If medicine is to be given *when needed*, please describe conditions________________________________

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Please list any significant side effects:____

Length of time this treatment is to continue (no longer than one school year)_________________________

Known allergies/other information____

It is my understanding that the school nurse of Tuckerton Elementary School charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alterations from the above will occur only with written directions from the attending physician.

Please indicate below whether the above named student may or may not have his/her daily medication suspended for a field trip. Please understand that efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs are in attendance. The district cannot always guarantee the availability of a substitute nurse. A parent or guardian may accompany the student on a field trip for the purpose of administering medication.

_____YES _____NO This drug may be omitted on half days and field trips.

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Physician's Name (PRINT) Physician's Signature (*Stamped signature NOT acceptable*) DATE

PO Box 217, Marine Street, Tuckerton, NJ 08087 - Fax # 609-296-1480