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

ST. MICHAEL THE ARCHANGEL SCHOOL
51 West North Street
Clayton, NJ 08312-1220
(856) 881-0067
Fax # (856) 881-4064

PHYSICIAN MEDICATION ORDER FORM

•SIGNED ORIGINAL ORDER REQUIRED•

Student's Name _____ Grade _____

Nonpublic School _____

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

***PHYSICIAN TO COMPLETE:**

Diagnosis: _____

Medication: _____

Dosage: _____ Route: _____ Time: _____

Special Instructions: _____

Precautions/Side Effects: _____

_____

Date _____ Physician Signature _____

(Original / No signature stamps please)

Physician Name _____

Address _____

Telephone No. _____

*** Please note: A school nurse may not always be available during school hours to administer this medication. Please contact the school principal to determine the manner in which medication will be dispersed 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

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.

_____ has been designated to administer a pre-filled, single dose auto-injector
(Name of Designee)
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**

PHYSICIAN'S/OR NURSE PRACTITIONER'S AUTHORIZATION/ASSURANCE STATEMENT FOR EMERGENCY ADMINISTRATION OF EPINEPHRINE

I certify that _____ is under my care for _____, a life-threatening condition and has a documented history of anaphylaxis. I am recommending that the above named student be administered a pre-filled single dose auto-injector mechanism containing epinephrine for anaphylaxis since he/she does not have the capability for self-administration of the medication.*

Name and purpose of medication: _____

Indications for emergency administration of epinephrine (specific signs and symptoms): _____

_____

Identification of chronic medical problems: _____

Prescribed dosage and schedule: _____

Length of time medication be taken: _____

Possible side effects and/or special precautions: _____

_____ _____
Prescribing Physician's/Nurse Practitioner's Signature Date

_____ _____
PLEASE PRINT NAME AND ADDRESS OF PRESCRIBING PHYSICIAN TELEPHONE #

*** Please note: The training of a designee and/or the physician's order for a medication does not guarantee the school nurse or designee will be available during all school hours.**