**Clearview Regional High School District**
**625 Breakneck Rd., Mullica Hill, New Jersey 08062**
**School Nurse 856-223-2719 (Fax 856-223-8728) – High School**
**School Nurse 856-223-2755 (Fax 856-223-2779) – Middle School**

# Administration of Medication

**MUST BE RENEWED EVERY SCHOOL YEAR**

**Student** _____ _____ _____
**Last First** **Grade** **Birth Date**

**Physician – Please Print Information**

**Medication** _____

**Dose**_____ **Time** _____

**Diagnosis**_____

**Side Effects** _____

**The student is authorized to self-medicate only in an emergency situation i.e., epi-pen and inhalers. All other meds are administered by the nurse. If the condition is life threatening, I further certify that the pupil is capable of and has been instructed in the proper method of self-administration of this medication.**

_____ _____
**Physician, Dentist, Nurse Practitioner – Name (Print)** **Name (Signature)**

_____
**Address**

_____ _____ _____
**Office Phone** **Fax** **Date**

**Dear Parent or Guardian:**

**Please have your physician complete this form for prescription or over the counter medications to be administered during the school day. It is recommended the first dose of medication be administered at home to observe any side effects.**

**Prescription medication and over the counter medication must be in original container. Upon request, pharmacists have labeled empty containers to be used for home and school.**

**I give permission for my child to receive the medication as directed by our physician. This authorization is effective for this school year and must be renewed for each subsequent school year. It will be my responsibility to get my child's medication on the last day of school.**

**I agree that, pursuant to N.J.S.A. 18A:40-12.3(d), I shall indemnify, hold harmless and defend the Clearview Regional High School District, its employees and agents, from and against any and all costs, expenses (including reasonable counsel fees), liabilities, judgments, losses, damages, suits, actions, fines, penalties, claims or demands of any kind and asserted by or on behalf of any person or entity arising out of or in any way connected with the self-administration of medication by**

_____ _____ _____
**Date** **Parent or Guardian's Signature** **Phone (During School Hours)**

Revised 4/20/06