ELSINBORO SCHOOL DISTRICT
Medication Form
(Fax) 856-935-6944
2018-2019

Student: ____ Date: ___________________

Date of Birth_________________ Age:________ Grade/Teacher __________________

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis: ____

Name of medication ____

Form of medication/treatment
_____ Tablet/capsule _____ Liquid _____ Inhaler _____ Injection
_____ Nebulizer _____ Other: _______________________________

Instructions (Schedule and dose to be given at school) ___________________________________

____

Restrictions and/or important side effects:____

This student is both capable and responsible for self administering this medication:

(Inhaler & Epipen only) ______ Yes-supervised ______ No

This student may carry medication at school ______ Yes ______ No

This student may carry medication on class trip _______ Yes ______ No

Date: _______________ Physician's Signature: ____________________________________

Physician's Name: ____
Address: ____
Phone Number: ____

To be completed by parent/guardian

I give permission for my son/daughter (Name of child) __________________________________
to receive the above medication at school. Parents are required to bring the medication to school in its original container.
Parent's signature: ____

ELSINBORO SCHOOL DISTRICT

Dear Parent:

Confidentiality laws prohibit me from notifying other staff members of any students with medical conditions such as asthma, allergies, seizure disorders and other disabilities which may not be public knowledge. Therefore, I am asking your permission to share this information with other school staff that will be with your child during the school day.

Thank You,

Mrs. Gallagher RN, CSN

I give permission to share medical information about my child, ___________________________ with school staff as nurse deems necessary.

____ _________________

Parent Signature Date