SOMERSET COUNTY VOCATIONAL & TECHNICAL SCHOOLS
P.O. Box 6350 • 14 Vogt Drive • Bridgewater, NJ 08807-0350 • (908) 526-8900 • www.scvths.org

Medication Order Form for Somerset County Vocational Technical Schools

STUDENT INFORMATION:

Student Name: _____ Birth Date: _____
Grade: _____
Parent/Guardian Name: _____
Home Address: _____
Parent/Guardian Phone No. Home: _____ Work: _____ Cell: _____

MEDICAL PROVIDER INFORMATION:

Licensed Medical Provider: _____
Address: _____
Phone: _____

Physician Stamp

MEDICATION INFORMATION:

Name of Medication: _____
Diagnosis: _____

Start Date: _____
Medication to be continued until: _____

Route of Administration: _____
Dosage: _____
Frequency: _____
Time(s) of administration: _____

Specific Directions for administration: _____
Significant side effects, contraindications, or adverse reactions:
_____

I request that the medication, named above, be given to my child. The medical provider explained to me the medication, its purpose and possible complications. I hereby acknowledge that the SCVTHS School District shall incur no liability as a result of any injury arising from the administration of this medication and herby indemnify and hold harmless the SCVTHS Board of Education and its employees or agents from any claims arising out of the administration of this medication.

Parent/Guardian Signature_____ Date_____
Medical Provider Signature_____ Date_____

PLEASE NOTE: This completed form, along with the medication, must be brought to the school nurse by the parent/guardian or adult student. The medication must be in the original container appropriately labeled by the pharmacy or medical provider.

SELF ADMINISTRATION OF MEDICATION

Only **life-threatening medications** designated by New Jersey State regulators may be self-administered. I hereby grant consent for the student to self-administer the above named medications. (Parent/Guardian and the student's medical provider must both sign this section in order for student to self-administer medication.)

Parent/Guardian Signature_____ Date_____
Medical Provider Signature_____ Date_____

Revised 6/12