



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 _____



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 SCVTH School District shall incur no liability as a result of any injury arising from the administration of this medication and hereby 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: _____