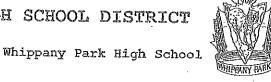


## HANOVER PARK REGIONAL HIGH SCHOOL DISTRICT

\_\_ Hanover Park High School \_\_



## Physician's Order for Administration of Medicine at School

Physician's prescribing medication that must be administered to pupils during school hours or at school activities for periods of more than ten school days or as needed throughout the school year are requested to complete this information form. The form must be filed with the school nurse prior to the start of medication at school. This order is valid only for the school year it is issued.

I am treating the following student and have prescribed medication which must be administered during school hours:

Student	_ Date of Birth		
Name of medication			· · · · · · · · · · · · · · · · · · ·
Reason for medication			
Form of medication/treatment			
Tablet/capsuleLiquidInhaler	Injection	Nebulizer	Other
Schedule and Dosage to be given at school			,
Length of Time for Medication			
State date of medication			
Stop date of medication			
OR .	·		
Medication is to be administered for ep	oisodic/emergency	events only.	
Restrictions and/or Important Side Effects			
None anticipated			
The following restrictions and/or critic	cal side effects mu	st be noted:	
<i>,</i>	(Please also complet	e the reverse side	)

Special st	orage requirementsNone	Refrigerate
Ot	her	·
Administ	ration of the medication shall be p	erformed by:
	The school nurse/school distr	rict designee
	OR	
	This is a life-threatening situal the medication.	tion and the pupil should be permitted to self-administer
·	that may require an immediate re	ministered by the school nurse. In the case of life-threatening illness esponse to specific symptoms or sequelae that if left untreated may e physician must also complete a. and b. below to authorize self-
	a. I certify that this pupil is	being treated for the following life-threatening illness:
	certify that this pupil is	self-administer the above-prescribed medication. I further capable of, and has been instructed in, the proper method of above-prescribed medication.
Please in	dicate if you have attached additio	nal information to this form. Yes No
Date	Pt	nysician's Signature
Physician	n's Name	
Address_		
_		
Telephor		
• .		•
HPRHSI	3/09	
•		Date Received:
		Approved:

## HANOVER PARK REGIONAL HIGH SCHOOL DISTRICT

Hanover Park High Sc	hool Whippany Park High School
Parent/Guardian's Request For	Administration of Medication at School
This form is to be completed by parents/guardians of were the pupil's physician has prescribed medication activities for periods of more than ten school days or ne	pupils of the Hanover Park Regional High School in situation that must be administered during school hours or at school eded
I/We are the parents/guardians of the following must be administered during the school hours:	student whose physic ian has prescribe medication which
Student	Date of birth
Name of medication	
Reason for medication	
This medication will be administered by:	
The school nurse /school district des	signee
OR	
	condition and the pupil should be permitted to self- erse side of this form is also completed.)
symptoms or sequelae that if left untreated may le	ndition that requires an immediate response to specific ead to potential loss of life. In accordance with N.J. Law nations only when authorized by the parents/guardians and
I/We request that the school authorize administrat Board of Education Policy JHCD. I/We and our Education and its employees or agents for the adm	tion of medication during school hours in accordance with child agree I/we/he/she shall hold harmless the Board of inistration of this medication during school hours.
Parent Name	Signature
Parent Name	Signature
Pupil Name	Signature
Data	

Please see reverse side of this form.

I/We are the parents/guardians of the following pu Statutes 18A:40-12.3 for our pupil to self-adminis	upil and request permission under the provisions of New Jersey ster medication for a potentially life-threatening illness.		
Student	Date of birth		
Name of Medication			
I/We certify that our pupil suffers from the followi	ing life-threatening illness:		
certification of the pupil's physician stating that th	ted medication as required. I/We shall obtain and submit the required ne pupil does require self-medication due to a potentially life-lf-administration and has been instructed in the proper administration		
Education, its employees and/or agents shall incur administration of the medication by our pupil. I/W the Board of Education, its employees and/or agen self- administration of this medication by our pupi	ion that the Hanover Park Regional High School District, the Board of r no liability as a result of any injury arising from the self- le acknowledge that the Hanover Park Regional High School District, at shall incur no liability as a result of any injury arising from the il and shall indemnify and hold harmless the District, the Board of y and all claims that may arise our of the self-administration of		
/We understand that this approval is granted for t school year.	the current school year and must be renewed for each subsequent		
Parent Name	Signature		
Parent Name	Signature		
Pupil Name	Signature		
Date:			
	Date Received:		
	Approved:		

Complete this additional side of the form ONLY if you are requesting permission for your pupil to self-administer

medication for a potentially life-threatening illness.