ADMINISTRATION OF MEDICINE FORM

_____ _____

STUDENT NAME **GRADE/TEAM**

I. DOCTOR'S REQUEST/INSTRUCTIONS FOR MEDICINE TO BE GIVEN BY SCHOOL NURSE.
TO BE FILLED OUT BY PHYSICIAN

The following medication is to be administered to my patient. _____

MEDICATION _____ DOSE AND ROUTE _____

TIME GIVEN _____ DIAGNOSIS _____

SIGNIFICANT SIDE EFFECTS _____

LENGTH OF TREATMENT _____ _____
M.D. Signature

_____
Print M.D. Name

II. DOCTOR'S REQUEST / INSTRUCTIONS FOR STUDENT SELF-ADMINISTRATION OF MEDICATION FOR A POTENTIALLY LIFE THREATENING ILLNESS.

TO BE FILLED OUT BY PHYSICIAN

The following medication is to be self-administered by my patient, _____
I hereby certify that my patient has a life threatening illness and that my patient is capable of and has been instructed in the proper administration of the required medication.

MEDICATION _____ DOSE AND ROUTE _____

TIME GIVEN _____ DIAGNOSIS _____

LENGTH OF TREATMENT _____

SIGNIFICANT SIDE EFFECTS _____

_____ _____
Date M.D. Signature

_____
Print M.D. Name

III. PARENT REQUEST AND RELEASE TO BE COMPLETED BY PARENT/GUARDIAN

I request my child, _____ to (receive) (self-administer) the medication designated above.
I have been informed by the school district that the school district, its agents, servants, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the TENAFLY BOARD OF EDUCATION, its agents, servants, and employees from any and all claims and shall defend any lawsuit that may arise out of or in connection with the administration of medicine by my child.

_____ _____
Date Signature of Parent/Guardian