GLASSBORO PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Physician Certification for Administration of Medication in School

Student Name ______________________ Diagnosis ______________________

Reason for Medication ____

Medication to be Administered ______________________________________

Dosage and Route ____

Time to be Administered ____

Possible Adverse Reactions ____

Medication Start Date __________________ Medication Stop Date ______________

Special Instructions or Comments ____________________________________

This student is permitted to self-medicate and has been instructed on self-medication of this medication. Yes ________ No ________

Physician Name (Print) ____

Physician Signature __________________________ Date __________________

Physician Address (or office stamp) ____________________________________

Physician Phone Number (or office stamp) ______________________________

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Parent/Guardian Certification for Administration of Medication in School

I give permission for my child ______________________________ to receive the above medication at school in accordance with Glassboro Board of Education policy. I have received a copy of and agree to comply with Guidelines for Administration of Medication in School. I understand that a new medication order will be required for any dosage or time changes and understand that medication must be brought to school in original container with prescription label attached.

Parent Name (Print) ____

Parent Signature ____________________________ Date __________________