PHYSICIAN MEDICATION ORDER FORM
●SIGNED ORIGINAL ORDER REQUIRED●

Student's Name ___________________________ Grade _______ DOB ________

Nonpublic School _______________________________________________________

* PLEASE PROVIDE A SEPARATE FORM FOR EACH MEDICATION THAT IS TO BE ADMINISTERED.

*PHYSICIAN TO COMPLETE:
  Diagnosis: _____________________________________________________________
  Medication: ______________________________ DC Date: ______________________
  Dosage: ________ Route: ________ Time: ________________________________
  Special Instructions: __________________________________________________
  Precautions/Side Effects: ______________________________________________

Date _______________  Physician Signature ________________________________
  (Original / No signature stamps please)

Physician Name ________________________________
Address _______________________________________
Telephone No. ________________________________

* Please note: A Gloucester County Special Services School District (GCSSSD) nurse is not always
available during school hours to administer this medication. Please contact the school principal to
determine the manner in which medication will be dispensed in the absence of a GCSSSD nurse.

* A medication order is effective July 1 - June 30 of each school year and must be renewed annually.

I give permission for (name of student) ___________________________
to receive medication at school as prescribed by Dr. ______________________________

I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN
THE ORIGINAL CONTAINER, PROPERLY LABELED, AND WILL PICK UP ANY UNUSED
MEDICATION. (STUDENTS ARE NOT PERMITTED TO CARRY MEDICATIONS TO OR FROM
SCHOOL.)

Date ___________________  Parent/Legal Guardian Signature _________________

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GLOUCESTER COUNTY SPECIAL SERVICES SCHOOL DISTRICT
PERMISSION FOR EMERGENCY ADMINISTRATION OF EPINEPHRINE

THIS ORDER MUST BE RETURNED IN ITS ORIGINAL FORM. FAXES AND COPIES WILL NOT BE ACCEPTED.

I, the parent/guardian of ________________________ authorize my child, a pupil at ________________________ (Name of Student) (Nonpublic School) School to be administered a pre-filled, single dose auto-injector mechanism containing epinephrine (provided by me) prescribed by our physician/or nurse practitioner as described below for anaphylaxis since he/she has a documented history of anaphylaxis and does not have the capability for self-administration of the medication. If the school nurse is not available, a designee will administer a pre-filled, single dose auto-injector mechanism containing epinephrine for anaphylaxis to my child. The designee has been properly trained by the school nurse using the “Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse” established by the Department of Education in consultation with the Department of Health and Senior Services.

I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. I further understand that neither the GCSSSD Board of Education, any district employee, chief school administrator of a nonpublic school, nor nonpublic school employee shall be responsible for any liability as a result of any injury arising from the procedures utilized for emergency administration of epinephrine to my child and that I shall indemnify and hold harmless the district or nonpublic school and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child.

______________________________  ________________________
Parent/Guardian Signature Date