



SAINT ALOYSIUS

CHURCH AND SCHOOL

935 Bennetts Mills Road

Jackson, N.J. 08527

P 732-370-1515

F 732-370-3555

MEDICATION ORDER

TO BE GIVEN TO SCHOOL NURSE

SCHOOL YEAR _____

No medication will be administered without the written order from the student's physician and parent.

PHYSICIAN, PLEASE NOTE: Do not leave any blank spaces. This form will be returned to you and may cause a delay in the administration of your patient's medication.

Student Name: _____ D.O.B. _____

Grade: _____

Name of Medication: _____

Dose: _____ Route: _____ Time(s): _____ Total dose(s) per day: _____

If PRN provide criteria:

Precautions/side effects, if any (i.e. No heights or climbing ladders, no waterway activities - risk of drowning, etc)

Date: _____

Physician's Name: _____

Signature: _____ Date: _____

Address: _____

City: _____ State: _____ Phone: _____

PARENT/GUARDIAN COMPLETE THIS SECTION:

I give permission for the school nurse to administer the above medication, as prescribed by my child's physician, to my child, _____.

I understand that no medication will be given to my child unless it is brought to school in the original container, properly labeled, from the pharmacy/manufacturer.

Parent/Guardian Name: (please print) _____

Signature: _____ Date: _____