Ronald F. Corn,
High School Principal
Michael J. Renner
Assistant Principal
Eric Rosen,
Assistant Principal
Joseph C. Cramp, Jr.,Director of Athletics & Student Activities

HADDON HEIGHTS
Junior/Senior High School

301 Second Avenue, Haddon Heights, NJ 08035 ● (856) 547-1920 / FAX (856) 547-6808

HADDON HEIGHTS SCHOOL DISTRICT
AUTHORIZATION FOR THE DAILY ADMINISTRATION OF PRESCRIBED MEDICATIONS FORM
BY THE SCHOOL NURSE

The following is to be completed by the **Parents/Guardians**: School:
Child's Name: _____ Sex: _____ Birth Date: ____ / ____ /
Last First MI

Physician's Name_____Address_____Phone Number_____

We/I request that our/my child be assisted by the school nurse in taking medication(s) as prescribed below by our/my child physician. We/I will indemnify and hold blameless the school district against any injury or claims that arise as a result of the nurse's administration of my child's medication. We/I realize that we/I must renew this certificate annually. We/I also give the school nurse permission to contact the physician below with regards to matters concerning our/my child's medication or condition. We/I understand that the school district and its employees and agents shall incur no liability as a result of any injury arising fro the administration of medications of our/my child. We/I further understand we/I hereby indemnify and hold harmless the school district and its employees and agents against any injury or claims arising out of the nurse's administration of our/my child's medications.

_____

Date Parent/Guardian's Signature Home Phone # Work/Emergency #

_____

Date Parent/Guardian's Signature Home Phone # Work/Emergency #

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

Child's Name: _____ Child's Diagnosis: _____

Medication: _____ Dosage: _____
Frequency or time of day to be given at school:

If medicine is to be given *when needed*, please describe conditions:

Please list any significant side effects:

Length of time this treatment is to continue (no longer than one school year):

Known allergies/other information:

Please note, if a child has potentially life threatening condition, the Self-Medication Dispensing Form must be completed and signed by both the ordering physician and the parent prior to the student being allow to carry his/her medication. Contact the school nurse for the appropriate form.

Our Mission

The Haddon Heights Public Schools will educate students to approach the future as confident, creative, ethical, and productive individuals by providing challenging and enriching learning experiences.

An Equal Opportunity Employer

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It is my understanding that the school nurses of Haddon Heights charge with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribes the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration from the above will occur only with written directions from the attending physician.

For the emergency administration of epinephrine for anaphylaxis this form may be signed by either the physician or advanced practice nurse. In that case, the student named above requires the administration of epinephrine for anaphylaxis and does not have the capability for self-administration of the medication.

In addition, please indicate below whether the above-named student may or may not have his/her daily medications suspended for a field trip. Please understand that efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs are in attendance. The district cannot always guarantee the availability of a substitute nurse. A parent or guardian may accompany the student on a field trip for the purpose of administering medication.

_____ YES _____ NO This drug may be omitted on half days and field trips.

/_____/_____
Physician's Name (Print) Physician's Signature (stamped signature is **NOT** acceptable) Date

Office Stamp: _____

H:nurseforms:adminmed

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