Sussex County Charter School for Technology
Medication Administration during School/Field Trips

This form must be completed fully in order for the school to administer required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

*Prescription medication must be in a container labeled by the pharmacist or provider.
*Non-prescription medication must be in the original unopened container with the label intact.
*An adult must bring the medication to the school.
*The School nurse (RN) will call the prescriber, as allowed by HIPPAA, if a question arises about the medication.

Prescriber's Authoriziation

Student Name:___________________________________ DOB:_______________

Condition for prescribed medication:____

Medication Name:____

Dose:__________________________ Route:______________________

Time/Frequency of administration:____

Side Effects:____

End Date:_______________________________________

____ I certify that the above named student is capable of and has been instructed in the proper administration of this medication. I recommend this student be allowed to carry and self-administer this medication for his/her life threatening condition. (NJSA 18A:40-12.3)

____ Student is not capable of self-administering medication for his/her life threatening condition and requires assistance.

____ This medication is not for a life threatening condition. Medication shall be held and dispensed by the school nurse or RN.

Physician Signature: _______________________________ Date:________________________

Physician's Stamp

Parent/Guardian Authorization

I give my permission for the above medication to be administered to my child, either by self-administration or administration by the school nurse or (RN), as indicated by the above physician. I certify that I have legal authority to consent to medical treatment for the above named student, including the administration of medication at school/field trip. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse or (RN) to communicate with the healthcare provider as allowed by HIPAA. I hereby relieve the Board and its employees of any and all liability that may result from the administration, either by self-administration or administration by the school nurse or (RN), of this medication to my child.

Parent/Guardian Signature:____________________________ Date:____________________

Cell Phone:______________________ Work Phone:______________________