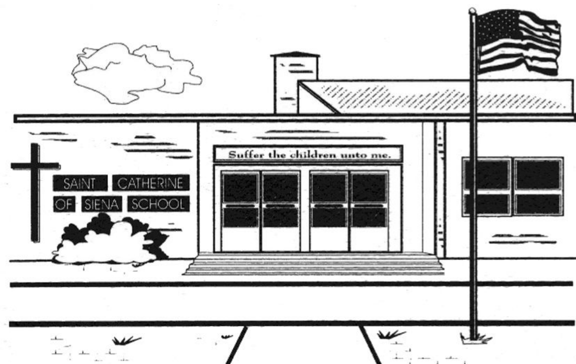

ST. CATHERINE OF SIENA SCHOOL

Middle States Accredited

39 E. Bradford Avenue, Cedar Grove, NJ 07009

Telephone 973-239-6968 • Fax 973-239-1008

www.scs-school-cedargrovenj.org

MEDICATION CONSENT FORM

Student's Name: ____ D.O.B. ________________

Parent/Caregiver's Name ____ Date: _________________

Telephone No.: (Home) ______________________ (Work) ___________________ (Cell) ______________

PART 1: TO BE COMPLETED BY STUDENT'S PHYSICIAN OR DENTIST

PLEASE COMPLETE ALL SECTIONS THAT APPLY (One medication per consent form)

A. MEDICATION ORDERS:

I certify that it is essential to the health of ____________________________________ that the following medication be administered by the school nurse during school hours as directed.

Diagnosis: ____

* Name of medication: ____ Dosage: ________________

Mode of Administration: __________________________ Frequency of Administration: __________

Time of Administration: _______________ Side Effects/Precautions: _________________________

Length of time order is valid (may not exceed school year): _________________________________

* Name of medication: ____ Dosage: ________________

Mode of Administration: __________________________ Frequency of Administration: __________

Time of Administration: _______________ Side Effects/Precautions: _________________________

Length of time order is valid (may not exceed school year): _________________________________

B. MEDICATION SCHEDULE ADJUSTMENTS:

If medication is to be given on a regular basis, please instruct below for special circumstances. Teaching staff will not give medication on class trips and students may not self-administer any medications except those for "Life-threatening conditions" (N.J.S.A. 18a:40-12.3). Check all that apply:

_____ Medication may be omitted on class trip.
_____ Administer the medication when the student returns from class trip.
_____ Parent will administer medication to his/her child while accompanying class trip.

- CIRCLE ONE: Administer/Do not administer medication on early closing days.
- CIRCLE ONE: Administer/Do not administer medication on delayed opening days.

____ When Epinephrine and Benadryl are ordered for an allergic reaction, Benadryl may be omitted from treatment plan in the absence of an authorized licensed staff member (School Nurse) and when student is not capable of self-administering.

Signature of Physician/Dentist: ____ Date: _________________

Physician/Dentist Stamp: ____ Phone: ___________________________

(over)

PART 2: (To be completed by Parent/Caregiver)

A. PARENT/CAREGIVER PERMISSION FOR SCHOOL NURSE ADMINISTRATION OF MEDICATION

To be completed by Parent/caregiver: I giver permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required.

I disclaim all liability of St. Catherine of Siena School as it concerns the use of this medication.

If a pre-filled, single dose auto-injector of Epinephrine is prescribed for a severe allergic reaction (anaphylaxis), it will be administered by the school nurse and/or by a delegate trained by the school nurse when the school nurse is not present. Bea advised that the school nurse is present at St. Catherine's on a part-time basis and thus has limited hours at the school.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the school.

____ _________________________

Parent/Caregiver Signature Date

5/2016