SAINT JEROME SCHOOL

250 Wall Street
West Long Branch, New Jersey 07764
Phone (732) 222-8686 Fax (732) 263-0343

Saint Jerome School Medication Form

School Year _____

Part I – To be completed by the physician

Student Name _____ Student Birthdate _____

Diagnosis _____

Name of Medication _____

Dosage / Mode / Frequency _____

Side Effects _____

Permission granted for self-medication. Student has been trained and is proficient in self- administration of the prescribed medication ☐ *YES* ☐ *NO*

THE ABOVE ORDER IS VALID FOR THE CURRENT SCHOOL YEAR

Physician Signature and Stamp _____

Date _____

Part II – To be completed by the parent or guardian

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

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

Parent / Guardian Signature_____

To be completed by the student's parent or guardian (if applicable)

I hereby request self-medication privileges for my child. He/she will demonstrate proper knowledge in the use of the prescribed medication to the school nurse. I understand that St. Jerome School and its employees or agents shall incur no liability as a result of injury arising from the self-administration of medication by the student.

Parent / Guardian Signature_____