GLOUCESTER COUNTY PUBLIC SCHOOLS
MEDICATION CONSENT FORM

We attempt to discourage administration of medication during school hours and request that whenever possible medication be administered at home. We realize that this is not always possible and will cooperate in the administration of Food and Drug Administration (FDA) approved medication when needed.

1. **PRESCRIPTION MEDICATIONS:** The physician **must** complete this form detailing the name of the drug, dosage, and time intervals that the medication is to be taken. The parent or guardian must sign this form requesting that the school district comply with the physician's order. Medication **must** be brought to school in a container appropriately labeled by the pharmacy or physician. Asthma Action Plans, Diabetes Management Plans, Emergency Action Plans, etc. do not require the medication consent form **as long as** they are completely filled out and signed by the doctor, parent, and school nurse.

2. **OVER THE COUNTER MEDICATIONS:** All over the counter medication **must** be in the original container and be provided by the parent or guardian. The parent or guardian **must** complete this form requesting that the school district administer the medication.

3. If medication is brought to school by the student, the appropriately labeled container **must** be placed in a sealed envelope. The number of pills being sent **must** be indicated on the envelope.

4. All medication **must** be kept in the school clinic. Violations of this policy could place the student in violation of the Substance Abuse Policy.

5. Medication **MUST** be picked up by the parent/guardian or designated adult. ALL medication not picked up by the last day of school will be destroyed.

PLEASE FILL IN AND SIGN THIS FORM (one medication per form):

Student's LEGAL Name: _____

Date of Birth: _____ Grade: _____ ID#: _____

Date of Order: _____ **Allergies:** _____

Condition Being Treated: _____

Name of Medication: _____

Dose and frequency: _____

Possible side effects: _____

Duration of Order: _____***School Year 2021-2022***_____

_____
Physician's Stamp Signature of Physician Telephone Number

I request that the school give the above medication.

_____
Signature of Parent/Guardian Date Daytime Telephone

School Name: _____ **Fax #: _____**

Signature of School Nurse:_____ **Expiration Date of Medication:_____**

Form SS 96-09
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