PITTSGROVE TOWNSHIP SCHOOLS
Pittsgrove, New Jersey 08318-3950

Permission to Administer Medications
Overnight Field Trips (Only)

Student Name: _____ DOB: _____

Allergies: _____

Grade: _____ Homeroom Teacher: _____

FOR OVERNIGHT FIELD TRIPS: An order from your health care provider is required for all over the counter and prescription medications needed on an overnight field trip. The nurse dispenses all medicine at breakfast and bedtime unless otherwise indicated. A student may only self-administer a rescue inhaler, auto inject epinephrine or insulin/glucagon. ***No order is needed for Tylenol, Advil, Benadryl, Dramamine, Imodium or Tums. These medicines are ordered and provided by the school district.*** This medication order is valid for one school year only AND for overnight trips only. This form may be used for all overnight trips during the current school year.

MUST Be Completed By Health Care Provider

Medication Name	Dose	Dosage time BREAKFAST (check if applicable)	Dosage time DINNER (check if applicable)	Dosage time OTHER (be specific)

Prescriber's Name/Title: _____

Prescriber's Telephone: _____ **Fax:** _____

Prescriber's Signature: _____ **Date:**_____

(Original signature or signature stamp ONLY)

(HCP-OFFICE STAMP REQUIRED)

MUST Be Completed By Health Care Provider

Self-Administer/Self Carry Administration of Emergency Medication Authorization/Approval

Parent permission and provider consent is required for students to self-administer and self-carry medication. Self-carry/self-administration of emergency medication such as Asthma inhaler, Epinephrine and Diabetic Medications/Glucagon may be authorized by the prescriber and must be approved by the school nurse according to the

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State medication policy. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. Prescriber's authorization for self-carry/self-administration of emergency medication:

Permission to Self/Carry and self administer at all times: ❒ Yes ❒ No

Prescriber's Signature: _____ Date:_____

(Original signature or signature stamp ONLY)

Parent/Guardian Name (Print) _____ Relationship to Student _____

Parent/Guardian Signature _____ Date _____

Permission to Administer Medications - CONTINUED
Overnight Field Trips (Only)

Student Name: _____ DOB: _____

Allergies: _____

Grade: _____ Homeroom Teacher: _____

To Be Completed By Parent/Guardian

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/ packaging with my child's name on it.

Parent/Guardian Name (Print) _____ Relationship to Student _____

Parent/Guardian Signature _____ Date _____

Phone _____

PARENT/GUARDIAN AUTHORIZATION: I/We request the school nurse to administer the medication as prescribed. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication during an overnight trip. I/We understand that at the end of the trip, an adult must pick up the medication, otherwise it will be discarded. I/We hereby release the Pittsgrove Board of Education, collectively and individually, its agents, employees and volunteers for any and all liability which may arise as a result of any injury arising from the administration of the above-listed medication by or to my/our child. Furthermore, I/we agree to indemnify, defend and hold harmless the Pittsgrove Board of Education from any claims arising from the administration of medication by or to our child. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPAA.

Parent/Guardian Signature _____ Date _____

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