Edgarton
Christian Academy

P.O. Box 646, 212 Catawba Ave.,
Newfield, NJ 08344
856-697-7300
856-697-7303
www.eca-pk8.org

SCHOOL YEAR 2023-2024
MEDICATION ADMINISTRATION
IN SCHOOL REGULATIONS REGARDING MEDICATION

Medication shall be administered in school only by a written order by the prescribing physician, along with a written request and a supply of medication from the parent/legal guardian. All medication must be properly labeled, in the original pharmacy container and brought to school by the parent/legal guardian. Any unauthorized medication found in the student's possession without proper documentation on file, will be taken and held in the school office, and the parent/guardian notified. This is for the safety of your child and others.

Medication in general, according to state law, will be administered or taken under the supervision of the school nurse. **Please note a school nurse may not always be available during school hours to administer medication.** Contact the school office to obtain times and days the nurse is assigned. Therefore, receipt of a doctor's note and written request from the parent does not guarantee that a medication can be administered during the school day.

A medication order is effective from July 1 to June 30 of each school year and must be renewed annually.

In the case of a **POTENTIALLY LIFE-THREATENING CONDITION** (i.e. epinephrine/inhaler usage), legislation has been passed which allows a student to carry a medication for immediate availability and self-administration. However, this situation **REQUIRES** proper documentation. Contact the school nurse in order to obtain the appropriate documents. In the case of a student with a potentially life threatening allergy, with documented history of an actual anaphylactic episode, provision of a nurse-trained designee for administration of emergency epinephrine, in the event a nurse is unavailable, is allowable under law. However, certain restrictions apply and you must contact the school nurse.

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PHYSICIAN MEDICATION ORDER FORM PER GLOUCESTER COUNTY
Signed Original Order Required

Student Name: ____________________________________ Grade: _________ DOB:___________________

Non Public School ____

Please provide a separate form for each medication that is to be administered.

***PHYSICIAN TO COMPLETE:**

Diagnosis: ____

Medication: _______________________________________ DC Date:________________

Dosage: ______________ Route: ______________ Time: ______________

Special Instructions: ____

Precautions/Side Effects: ____

____

Date: _______________________ Physician Signature: _________________________________

Original signature/No stamps please

PHYSICIAN NAME____
ADDRESS____
PHONE NUMBER____

***Please note: A GCSSSD nurse is not always available during school hours to administer this medication. Please contact the school principal to determine the manner in which medication will be dispensed in the absence of a GCSSSD nurse.**

A medication order is effective July 1-June 30 of each school year and must be renewed annually.

I give permission for ____to receive medication above at school as prescribed by Dr.______________________.

I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN THE ORIGINIAL CONTAINER, PROPERLY LABELED, AND WILL PICK UP ANY UNUSED MEDICATION. STUDENTS ARE NOT PERMITTED TO CARRY MEDICATIONS TO OR FROM SCHOOL.

_________________________ ____

Date Parent/Legal Guardian Signature

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SCHOOL YEAR 2023-2024
REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Student Name: ____________________________________ **D.O.B.**_______________ **Date:** ______________

Grade: _____________ **Teacher:** _______________________________________

PARENTAL REQUEST

I, the parent/guardian of ___________________________, authorize the Principal and School Nurse to permit the student to self-administer the prescribed medication as indicated. I understand and agree that the school, school nurse and principal shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the school, school nurse, and principal against any claims arising out of the self-administration of medication by the student.

I agree to bring a weekly supply of the medication to the school nurse. The medication will be brought to school in its original container appropriately labeled by my pharmacy.

____ _________________

Signature of Parent/Guardian **Date**

____ __________________

Address **Phone Number**

____

PHYSICIAN'S STATEMENT

In order to protect the health of ___________________________ **it is necessary for him/her to have the following medication during school hours.**

MEDICATION: ____

DOSAGE: ____

TIME TO BE ADMINISTERED: ____

LIST ANY POSSIBLE SIDE EFFECTS WHICH MIGHT BE EXPECTED:

____

DIAGNOSIS: ____

I request that the student be allowed to carry and self-administer the prescribed medication. I certify that the student is capable of, and has been instructed in the proper methods of self-administration.

____ ______________________________

Signature of Physician **Date**

____ ______________________________

Print/Stamp Physician Name **Phone Number**