

Delaware Valley Regional High School

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MEDICATION FORM

This form is to be completed for all medications **OTHER** than asthma medications and Epi-pens.

Student Name: _____ **DOB:** _____ **Class of 20** _____

School Year: _____ **Allergic to:** _____

Medications: _____ **Dosage:** _____ **Time:** _____

Side effects to observe for: _____

Activity restrictions based on medications effects: _____

Medication Order for Trips:

Yes **No**

_____ _____ On the occasion of a school event or trip at which a nurse is not present, this medication may be omitted or delayed. There is no hazard to the child's health by so doing. In some case, there may be a need to carefully monitor the child's behavior.

_____ _____ This medication should always be given at the times specified.

_____ _____ Other, please explain: _____

Medication Order for Early Dismissal Days:

_____ _____ Omit afternoon dose

_____ _____ Maintain original order

In the event that the student is not given his morning dose at home, the school nurse may give the medication listed above with parental permission. AM DOSE: _____

Signature of Physician: _____ **Date:** _____

Name and Address of Physician (print)

Parents - I hereby give permission for my child to receive medication at school as prescribed by my child's physician. I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Signature: _____ **Date:** _____

Reviewed by School MD: _____ **Date:** _____