

*Department Of Health
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Making It Better Together.

Personal Health Services

Division of Health

School Nursing Program

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Medication Administration in Schools

The following rules for the administration of medication in schools applies to BOTH prescription and non-prescription (e.g., Tylenol, cough syrup) medications in the school setting. No medication will be administered unless the following requirements are met.

- 1. A written order from the child's physician to include the name of the pupil, name of the medication, dosage, the time the medication is to be administered at school and the length of time to be given.*
- 2. A written medication administration form completed by the parent/guardian releasing the school and the school personnel from any liability there of. Medications are administered by a school nurse or designated responsible person. Medication Administration forms are available at the school office and from the school nurse.*
- 3. Medications are to be delivered to the school by the parent/guardian or a designated responsible person.*
- 4. All medication must be in the original container and clearly labeled.*
- 5. Controlled medications (e.g. Ritalin) require a thirty-day physicians renewal.*
- 6. At the end of the school year, medications must be picked up at school by the parent/guardian. Any remaining medication will be destroyed.*
- 7. If self-administration of a medication is prescribed, the parent/guardian and the authorizing physician must complete the medication administration form.*

School personnel shall not provide pupils with any medication until all the requirements are met.

CAMDEN CO. DEPT. OF HEALTH & HUMAN SERVICES
SCHOOL HEALTH PROGRAM
MEDICATION ADMINISTRATION FORM



This includes over-the-counter medication such as
Tylenol, ibuprofen, Benadryl, cough syrup, etc.



I request that the enclosed medication in the original container be administered to my child
as prescribed, and shall release school personnel from all liability.

NAME OF CHILD _____ GRADE _____

NAME OF MEDICATION _____

DOSAGE _____

PURPOSE _____

(parent/guardian signature) _____ (date) _____

TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date _____

Pharmacy _____ Phone # _____ Name of Medication _____

Name of Physician _____ Phone # _____

OF TABLETS RECEIVED _____

PHYSICIAN'S ORDERS

Name of Patient _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

COMMENTS _____

Doctor's Name (please print) _____

DOCTOR'S SIGNATURE _____