
SCHOOL YEAR 2026-2027
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.

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
ORIGINAL 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

SCHOOL YEAR 2026-2027
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