PRESCRIPTION MEDICATION AND PROCEDURE ADMINISTRATION

STUDENT: _____ AGE: _____ DOB _____

ADDRESS: _____ SSN: _____
City Zip Code

SCHOOL: _____ TEACHER: _____ GRADE: _____

PARENT/GUARDIAN: _____ HOME # _____ WORK # _____
(please print)

I authorize the Camden County School Clinics to administer the medication / procedure below for my child as prescribed by his/her physician. My child has received this medication / procedure at least 24 hours prior to the first administration at school and had no allergic reactions. I agree that the school will not be held responsible or liable for any illness or damage that may result from administration or lack of administration of this medication / procedure to my child or from the storage of medication / supplies for my child. If any information on this form changes it is my responsibility to notify the clinic in writing. I understand an authorized adult or myself must bring all medications to the clinic or building administrator's office. If I have any additional information, instructions, or comments I will make them a part of this record on the back.

I have read this form and understand and agree to my responsibility to the school, which is agreeing to assist me in this matter. I also authorize the prescribing physician to discuss with the clinic or other designated staff member any matter regarding the medication and/or procedure to be administered to my child.

_____ _____
Signature of Parent / Guardian Date

My child receives Medicaid / PeachCare. I understand that the school system is able to file with Medicaid for partial reimbursement for the administration of this medication / procedure and I do hereby authorize the school system to bill for the services below.

_____ _____
Signature of Parent / Guardian Date

Medicaid / PeachCare Number: _____

PHYSICIAN'S INSTRUCTIONS

Diagnosis: _____ Medication / Procedure: _____

Dose: _____ Time of School Administration: _____

Estimated Duration of Treatment: _____ Rehab Potential: _____

Goal(s): _____

Comments: _____

_____ _____ _____
Physician's Name (please print) Date Phone

_____ _____
Physician's Signature Address