



# GLOUCESTER CATHOLIC JUNIOR SENIOR HIGH SCHOOL

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## MEDICATION ADMINISTRATION FORM

**Please note students requiring an Epi-pen need a separate form filled out by their physician.**

### PHYSICIAN'S ORDERS

Patient Name: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Time it is to be administered: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Possible side effects: \_\_\_\_\_

If asthma inhaler: Has student been trained in proper self administration?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Print Physician's Name/ Date \_\_\_\_\_ Physician's Signature/ Date \_\_\_\_\_

Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

.....  
**PARENTS: PLEASE COMPLETE**

I request that the above medication be administered to my child as prescribed above by his/her physician. I release and hold harmless GCHS personnel from all liability.

Name of Student: \_\_\_\_\_

Mother's Signature/ Date \_\_\_\_\_ Father's Signature/ Date \_\_\_\_\_

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**FOR SCHOOL USE:**

Prescription # \_\_\_\_\_ Date: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Phone # \_\_\_\_\_