*Vocational Rehabilitation ● Early Intervention ● Special Education ● Here We Grow Learning Center*

# RELEASE FOR ADMINISTERING 72 HOUR MEDICATIONS

# **RELEASE FOR ADMINISTERING 72 HOUR MEDICATIONS** To be completed for every student or program participant:

**2019 - 2020**

A written order for medical treatment that program participants require during a 72-hour period must be on file in the school program nurse's office. The administration of medication will not be changed in any way unless a new form is submitted and signed by the attending physician. Medication should be brought into the program in the original container, appropriately labeled by the physician or pharmacist. **Parents/Guardians must supply all medications and all supplies including for dietary needs.**

[To be completed by parent/guardian]:

\_\_\_\_\_ I give permission for my child **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** to receive medication during a 72-hour period as prescribed by a physician.

----------- I understand that during a 72-hour period medical staff may not be available to dispense medication. However, a staff person who is trained in dispensing medications will be assigned to this task. For this reason, I am releasing St. John of God Community Services and Archbishop Damiano School from medical liability regarding the administration of medications.

\_\_\_\_ My child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_does not require any medication during a 72 hour period.

Parent/Guardian

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE FOR ADMINISTERING MEDICAL TREATMENT**

**PHYSICIAN'S WRITTEN ORDERS FOR MEDICAL TREATMENT**

**(Including prescriptions and over the counter medications)**

[To be completed by physician]:

Student's Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **Name of Medications(s)** | **Dose** | **Route** | **Exact Time(s) to be given during 72 Hours** | **Possible Side Effects** |
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Physician's

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_07/01/2019\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician's

Name P R I N T E D: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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