NAME OF STUDENT: _____ LC _____

MEDICATION POLICY FOR THE CHERRY HILL ENVIRONMENTAL EDUCATIONAL RESIDENCY PROGRAM

- **All medications including over the counter medications require a doctor's written order.**
- **The only exception is Acetaminophen (Tylenol) and Ibuprofen (Advil or Motrin) which can be given with the permission of a parent/guardian.**
- **All medication must be labeled clearly and be brought by a PARENT/GUARDIAN to the school nurse at least one week BEFORE the day of departure.**
- **Medications MUST be in the original pharmacy bottle with the label intact. Do not include extra doses. It must be in a large ziplock bag with the student's name, LC and date of trip.**
- **ONLY ONE MEDICATION SHOULD BE LISTED IN EACH PHYSICIAN ORDER AREA. See sample in packet. Additional sheets can be obtained from the nurse's office or downloaded off the nurse eboard.**

1. **PRESCRIPTION/OVER THE COUNTER MEDICATIONS:**

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN'S ORDERS (please print)

Name of Student: _____

Diagnosis: _____

Medication: _____

Dosage and Time: _____

Comments: _____

PHYSICIAN'S SIGNATURE: _____

2. **PRESCRIPTION/OVER THE COUNTER MEDICATIONS:**

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN'S ORDERS (please print)

Name of Student: _____

Diagnosis: _____

Medication: _____

Dosage and Time: _____

Comments: _____

PHYSICIAN'S SIGNATURE: _____

NAME OF STUDENT: _____ LC _____

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1. **PRESCRIPTION/OVER THE COUNTER MEDICATIONS:**

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN'S ORDERS (please print)

Name of Student: _____

Diagnosis: _____

Medication: _____

Dosage and Time: _____

Comments: _____

PHYSICIAN'S SIGNATURE: _____

2. **PRESCRIPTION/OVER THE COUNTER MEDICATIONS:**

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN'S ORDERS (please print)

Name of Student: _____

Diagnosis: _____

Medication: _____

Dosage and Time: _____

Comments: _____

PHYSICIAN'S SIGNATURE: _____

★ SAMPLE ★

NAME OF STUDENT: John Smith LC 1

MEDICATION POLICY FOR THE CHERRY HILL ENVIRONMENTAL EDUCATIONAL RESIDENCY PROGRAM

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- The only exception is Acetaminophen (Tylenol) and Ibuprofen (Advil or Motrin) which can be given with the permission of a parent/guardian.
- All medication must be labeled clearly and given to the school nurse one week BEFORE the day of departure.
- Medications MUST be in the original pharmacy bottle with the label intact. Do not include extra doses. It must be in a large ziplock bag with the student's name, LC and date of trip.
- ONE MEDICATION FORM SHOULD BE USED FOR EACH MEDICATION. Additional sheets can be obtained from the nurse's office or downloaded off the nurse eboard.

1. PRESCRIPTION/OVER THE COUNTER MEDICATIONS:

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE Carol Smith

PHYSICIAN'S ORDERS (please print)

Name of Student: John Smith

Diagnosis: allergies

Medication: Xyzal

Dosage and Time: 5mg at bedtime

Comments: _____

PHYSICIAN'S SIGNATURE: Dr. Jones MD

2. PRESCRIPTION/OVER THE COUNTER MEDICATIONS:

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE Carol Smith

PHYSICIAN'S ORDERS (please print)

Name of Student: John Smith

Diagnosis: hives

Medication: Benadryl

Dosage and Time: 25mg every 6 hrs. as needed

Comments: _____

PHYSICIAN'S SIGNATURE: Dr. Jones. MD