NAME OF STUDENT: LC	
M	EDICATION 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:

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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 order 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: John Smith

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 given to the school nurse one week BEFORE the

I request the enclosed medication to be administered to my child according to the physician's written accompany the medication. PARENT/GUARDIAN SIGNATURE	in the original pharmacy bottle with the label intact. Do not include in a large ziplock bag with the student's name, LC and date of trip. ORM SHOULD BE USED FOR <u>EACH</u> MEDICATION. Additional from the nurse's office or downloaded off the nurse eboard.
PARENT/GUARDIAN SIGNATURE PHYSICIAN'S ORDERS (please print) Name of Student: John Smith Diagnosis: Callergies Medication: XyZa Dosage and Time: Smg at beattime Comments: PHYSICIAN'S SIGNATURE: Dr. Jores MD PRESCRIPTION/OVER THE COUNTER MEDICATIONS: I request the enclosed medication to be administered to my child according to the physician's written accompany the medication. PARENT/GUARDIAN SIGNATURE Carely Jores (please print) Name of Student: John Smith Diagnosis: hives Medication: Denadry Dosage and Time: 25mg every 6 hrs. as ne	HE COUNTER MEDICATIONS:
PHYSICIAN'S ORDERS (please print) Name of Student: John Smith Diagnosis: Callergies Medication: Xyza/ Dosage and Time: Smg at beatime Comments: PHYSICIAN'S SIGNATURE: Dr. Jores MD PRESCRIPTION/OVER THE COUNTER MEDICATIONS: I request the enclosed medication to be administered to my child according to the physician's written accompany the medication. PARENT/GUARDIAN SIGNATURE Caral Jorial PHYSICIAN'S ORDERS (please print) Name of Student: John Smith Diagnosis: hives Medication: Benadry Dosage and Time: 25mg every 6 hrs. as ne Comments:	tion to be administered to my child according to the physician's written orders which will
Name of Student:	NATURE Carol Smith
Diagnosis:	PHYSICIAN'S ORDERS (please print)
Dosage and Time:	no Smith
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Dosage and Time:	
PHYSICIAN'S SIGNATURE: DA. DORLS MD PRESCRIPTION/OVER THE COUNTER MEDICATIONS: I request the enclosed medication to be administered to my child according to the physician's written accompany the medication. PARENT/GUARDIAN SIGNATURE COUNTER MEDICATIONS: PHYSICIAN'S ORDERS (please print) Name of Student: John Smith Diagnosis: hives Medication: Benadry! Dosage and Time: 25mg every 6 hrs. as ne	ima at bedtime
PRESCRIPTION/OVER THE COUNTER MEDICATIONS: I request the enclosed medication to be administered to my child according to the physician's written accompany the medication. PARENT/GUARDIAN SIGNATURE PHYSICIAN'S ORDERS (please print) Name of Student: Diagnosis: Diagnosis: Diagnosis: Doenadry Dosage and Time: 25 ng every 6 hrs. as ne Comments:	
I request the enclosed medication to be administered to my child according to the physician's written accompany the medication. PARENT/GUARDIAN SIGNATURE PHYSICIAN'S ORDERS (please print) Name of Student: Diagnosis: Medication: Benadryl Dosage and Time: 25 mg every 6 hrs. as ne	E. Dr. Jores mo
PARENT/GUARDIAN SIGNATURE PHYSICIAN'S ORDERS (please print) Name of Student: John Smith Diagnosis: hives Medication: Benadry! Dosage and Time: 25 ng every 6 hrs. as ne Comments:	HE COUNTER MEDICATIONS:
PHYSICIAN'S ORDERS (please print) Name of Student: John Smith Diagnosis: hives Medication: Benadryl Dosage and Time: 25 ng every 6 hrs. as ne Comments:	tion to be administered to my child according to the physician's written orders which will
Name of Student: John Smith Diagnosis: hives Medication: Benadry! Dosage and Time: 25 ng every 6 hrs. as ne Comments:	NATURE Carol Smith
Diagnosis: hives Medication: Benadry Dosage and Time: 25 ng every 6 hrs. as ne Comments:	PHYSICIAN'S ORDERS (please print)
Medication: Benadry Dosage and Time: 25 ng every 6 hrs. as ne Comments:	hn Smith
Dosage and Time: 25 mg every 6 hrs. as ne	S
Comments:	adryl
A ()	25 mg every 6 hrs. as needed
PHYSICIAN'S SIGNATURE: DI- JONES. MD	
	E. Dr. Jones. ms