

SC Special Services School District  
Cumberland Campus  
13 Ramah Road  
Bridgeton, NJ 08302  
(856) 459-2613



Ellison School  
1017 South Spring Road  
Vineland, NJ 08360  
(856) 691 - 1734

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**PHYSICIAN MEDICATION ORDER FORM**  
**\*Signed Original Order Required\***

Student Name: \_\_\_\_\_ Academic Year \_\_\_\_\_  
Grade: \_\_\_\_\_

Nonpublic School: \_\_\_\_\_

\*Please provide a separate form for each medication that is to be administered.

PHYSICIAN TO COMPLETE:

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

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Precautions/Side Effects: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature (ORIGINAL – NO SIGNATURE STAMPS, PLEASE)

\_\_\_\_\_  
Date

Physician Name: \_\_\_\_\_

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

Telephone #: \_\_\_\_\_

**\*Please Note: A school nurse may not always be available during school hours to administer this medication.**

- **A medication order is effective July 1 – June 30 of each school year and must be renewed annually.**

I give permission for (name of student) \_\_\_\_\_ to receive medication at school as prescribed above by Dr. \_\_\_\_\_.

**I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN THE ORIGINAL CONTAINER, PROPERLY LABELED AND WILL PICK UP ANY UNUSED MEDICATION.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date