Department of Special Services
Scotch Plains-Fanwood Public Schools

REQUEST FOR ADMINISTRATION OF MEDICATION

It is the policy of the Board of Education that:

- The school will not provide pupils with any medication without an order from the treating health care provider.
- Pupils requiring prescription or over the counter medication at school must have a written statement from the treating health care provider which identifies the diagnosis, the medication, the dosage, the times(s), for administration, and the number of days on which the medication is to be administered.
- A written statement is required from the parent giving permission for the prescribed medication and relieving the school of responsibility for any possible adverse effects of said medication.
- Parents must assume the responsibility for delivering medication in the original container to the school nurse. Medication is to be held by, and administered only by the school nurse.
- The school nurse may administer emergency medication for severe allergic reaction as authorized by the school medical inspector.
- In the absence of the school nurse, alteration in medication time schedule may be necessary.

REQUEST FROM PARENT

I hereby request that my child, _____, Grade____, at _____School, be administered medication during school hours or, on an overnight field trip, as prescribed by our health care provider whose written directions accompany this request. I understand that the ultimate responsibility for the administration of the medication is mine, and I understand that the duties of the school nurse may require her presence at an emergency or at another school at the time that the medication is needed. As long as proper procedures are followed, I release the School Board and the school staff from any responsibility for adverse effects due to administration or lack of administration of this medication. I will deliver the medication in the original container to the school nurse.

_____ _____
Signature of Parent Date

RECOMMENDATION OF PRIVATE PHYSICIAN

Student's name:_____**Diagnosis**_____

Medication:_____ **Dose:**_____**Time: _____AM/PM**

- ☐ **PRN every _____hours**
- ☐ **Daily**

Dates to be dispensed: (Check box)

- ☐ Entire School year
- ☐ All field trips (including overnight)
- ☐ Limited course of treatment: _____

Potential adverse reaction(s) _____

_____ _____
Signature of Health Care Provider **Date**

_____

Stamp/Address/Phone rev: 6/12