

Cranford Public Schools

ANNUAL REQUEST FOR ADMINISTRATION OF MEDICATION - SCHOOL YEAR 2016/17

Cranford Board of Education Regulation #5141.21 (a copy of which is printed on the reverse side of this form) requires that:

1. Pupils requiring medication at school (prescription or over-the counter) must have a written order from the family health care provider that identifies the medication, purpose of the medication, the dosage/route and the time(s) for administration on which the medication is to be administered.
2. A written statement is required from the parent/guardian giving the school nurse permission to administer medication(s) prescribed by the health care provider.
3. Parents/Guardians shall assume the responsibility for hand-delivering medication in the original container, identified by the pharmacy to the school nurse.
4. The medication shall be kept by the school nurse and administered only by the school nurse.
5. Apart from medications as noted above, the school nurse may administer emergency medication for severe allergic reactions as authorized by the district medical officer. In the event of such an emergency, the school shall make every reasonable effort to contact the parent/guardian.

DOCTOR'S ORDER FOR MEDICATION

To protect the health of _____, it will be necessary for him/her to have medication during school hours, prescribed by me, as follows:

Purpose _____

Dosage and Route _____

Medication _____

Time(s) to be given _____

PHYSICIAN'S OFFICE STAMP

Physician's Signature

Date

REQUEST FROM PARENT

I hereby request that my child, _____, who attends Grade _____, at _____ School, be administered medication during school hours as prescribed by our family physician whose written directions accompany this request. I understand that the ultimate responsibility for the administration of the medication is mine, and I am fully aware that the duties of the school nurse may require her presence 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.

***ON EARLY DISMISSAL DAYS OF SCHOOL (PLEASE CHECK ONE):**

I WANT the School Nurse to administer medication on early dismissal days.

I DO NOT WANT the School Nurse to administer medication on early dismissal days.

Date

Signature of Parent/Guardian

Primary Contact Cell Number

Secondary Contact Cell Number