THE PUBLIC SCHOOLS Department of Student Support Services West Orange, NJ 07052

To: Physicians & Parents

We are writing to ask for your cooperation as we attempt to best serve the children in our schools regarding the administration of medication during school hours.

The West Orange Public Schools' policy regarding the administration of medication during the school hours is as follows:

1) Parents & treating physicians are responsible for the diagnosis and treatment of a student's illness. The administration of prescribed medication to students during school hours will be permitted when failure to take such medicine would jeopardize the health of the student, or the student would not be able to attend school if the medicine was not available during school hours.

2) Pupils requiring medication at school must have a written statement from the family's physician that identifies the type, dosage, time schedule, purpose of the medication and possible side effects.

3) A written statement from the parent or guardian of the pupil giving permission for the school nurse to give the medication prescribed by the family physician is required.

4) Any medication to be administered during school hours must be kept in the health office.

Sincerely,

School Nurse

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PARENT'S REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

Student ____ DOB _______________Grade ______ School ______________________________

I, the parent of ____, request the school nurse administer the medication (Student's name) prescribed by ____ for the period from (Physician's Name) __________________________ to ______________________________.
(Date) (Date)

The medication is to be furnished by me and is to be pharmacy-labeled with the name of the medicine, the amount to be given, time of day to be taken, and the expected duration of treatment. The physician's name must also be on the label. The school nurse has my permission to contact Dr. ____ at _________________________________ to the administration and effect of the medication. (Telephone #)

____
(Parent's signature) (Date)

PHYSICIAN'S REQUEST FOR GIVING MEDICATION AT SCHOOL Date _______________________

Student's Name ____ DOB ____

To: ____, School Nurse at ____School Rx ____ Dosage ____ Time/special circumstances of administration ____ Period of Time ____ Purpose of Medication ____ Possible side effects ____

Physician's Signature ____ Date ____

Physician's Stamp ____