WEST ORANGE PUBLIC SCHOOLS

DEPARTMENT OF STUDENT SUPPORT SERVICES

179 Eagle Rock Avenue · West Orange · New Jersey · 07052
Telephone: 973-669-5400 Ext. 20538
Fax: 973-669-8601

MS. KRISTIN GOGERTY , DIRECTOR

MS. KAREN DEAS, SUPERVISOR, PRESCHOOL, K – 5

MRS. DAWN RIBEIRO, SUPERVISOR, 6-12

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) (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 _____