The Public Schools
Department of Student Support Services
West Orange, NJ 07052

To: Physicians and 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 we not available during the 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.

Sincerely,
School Nurse

PARENT'S REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

Student: _____ DOB:_____ Grade: _____ School: _____

I, the parent of _____, request the school nurse administer the medication prescribed by
(Student's name)
_____ for the period of time from _____ to _____.
(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
(Physician's name)
_____ to the administration and effect of the medication.
(Telephone #)

_____ _____
Parent's Signature Date

PHYSICIAN'S REQUEST FOR GIVING MEDICATION AT SCHOOL

Date: _____ Student: _____ DOB:_____
To: _____ School Nurse at _____ School

Rx _____
Dosage _____
Time/Special Circumstances of Administration: _____
Period of Time: _____
Purpose of Medication: _____
Possible Side Effects: _____
Physician's Name: _____ Date: _____

_____ _____
Physician's Signature Date

Physician's Stamp _____