WEST ORANGE PUBLIC SCHOOLS

179 Eagle Rock Avenue **West Orange, New Jersey 07052**
Department of Student Support Services (973) 669-5400 ext. 20538 Fax: (973) 973-669-8601

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 and/or during times of emergencies.

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

PARENT'S REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS/ EMERGENCIES

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 or DURING EMERGENCIES

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 Name _____Date _____