# 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

**PROVISION FOR EMERGENCY MEDICATION**

Student's Name _____ D.O.B _____

Dear Parent / Guardian:

As you are aware, the West Orange Public Schools is making preparations for emergency situations, as suggested by emergency management officials (please refer to the District's Emergency Preparedness Plan). It is our hope that our Crisis Management Plan will never be tested; however, we have the responsibility of planning for your child's safety.

Your child may have a health condition that requires daily medication/treatment that is taken before or after school hours. We are requesting that you contact your child's physician to obtain orders for the medication/treatment that would be needed to provide continuity of care and prevention of **serious** complications, in the event your child cannot leave the building and you cannot reach the school.

This procedure is not for routine medications, such as allergy, ADD/ADHS, asthma, etc., **unless** you, in consultation with the physician, indicate your child **would** require the medication in a disaster/crisis situation.

**Please use this form to indicate your intentions, and if you will be providing medication, bring the attached form to your physician to obtain authorization and specifications of the times of administration**. **You must also sign the form giving us consent to administer the medication**. After you and the physician have completed and signed this form, please send this and the original labeled medication container and/or supplies needed for a 72-hour period (3-day supply) to your school nurse.

Sincerely,

School Nurse

*Indicate your intentions below and if yes, return the Parent's/Physician's Request for Administration of Medication within 1 week of the date you sign this form along with the medication*.

_____ Yes, I will provide for my child's school nurse to hold his/her medication/treatment should my child ever require medication/treatment, as described above.

_____ No, I will not arrange for my child's medication/treatment, as described above.

*Should you have any questions, please do not hesitate to contact your school nurse.*

Parent's Signature: _____ Date: _____