

**OFFICE OF PUPIL SERVICES  
SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS  
SCOTCH PLAINS, NEW JERSEY 07076**

**REQUEST FOR ADMINISTRATION OF MEDICATION**

It is the policy of the Board of Education that:

1. The school shall not provide pupils with aspirin or any medication, including over-the-counter medication.
2. Pupils requiring medication at school must have a written statement from the family physician which identifies the diagnosis, the medication, the dosage, the times(s), for administration, and the number of days on which the medication is to be administered.
3. A written statement shall be required from the parent giving permission for the prescribed medication and relieving the school of responsibility for any possible adverse effects of said medication.
4. Parents must assume the responsibility for delivering medication in the original container to the school nurse. Medication is to be held by, and administered only by the school nurse.
5. The school nurse may administer emergency medication for severe allergic reaction as authorized by the school medical inspector.
6. In the absence of the school nurse, alteration in medication time schedule may be necessary.

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**REQUEST FROM PARENT**

Dear \_\_\_\_\_:

Principal

I hereby request that my child, \_\_\_\_\_, who attends Grade\_\_\_\_, at \_\_\_\_\_ School, be administered medication during school hours as prescribed by our family physician whose written directions accompany this request. I understand that the ultimate responsibility for the administration of the medication is mine, and I am fully aware that the duties of the school nurse may require her presence at another school at the time that the medication is needed. As long as proper procedures are followed, I release the School Board and the school staff from any responsibility for adverse effects due to administration or lack of administration of this medication. I will deliver the medication in the original container to the school nurse.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Address

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**RECOMMENDATION OF PRIVATE PHYSICIAN**

In order to protect the health of \_\_\_\_\_, it will be necessary for him/her to have medication during school hours, prescribed by me, as follows:

Diagnosis \_\_\_\_\_

Dosage \_\_\_\_\_

Medication \_\_\_\_\_

Time(s) to be given \_\_\_\_\_

Number of Days \_\_\_\_\_

Date: \_\_\_\_\_

RXII-4/02

\_\_\_\_\_  
Signature of Doctor