Department of Special Services
Scotch Plains-Fanwood Public Schools

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 other 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 effect 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.

REQUEST FROM PARENT

Dear _____:
School Nurse

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

_____
Address

RECOMMENDATION OF PRIVATE PHYSICIAN

Student's name: _____ Diagnosis: _____

Medication: _____ Dosage: _____

Time(s) to be given: _____ Number of days: _____

_____
Signature of Doctor

_____ _____
Date Doctor's Name and Address
(Stamp)