Cranford Public Schools

ANNUAL REQUEST FOR ADMINISTRATION OF MEDICATION - SCHOOL YEAR:_____

Cranford Board of Education Regulation #5330 Link to Board Policy

1. Pupils requiring medication at school (prescription or over-the counter) must have a written order from the family health care provider that identifies the medication, purpose of the medication, the dosage/route and the time(s) for administration on which the medication is to be administered.
2. A written statement is required from the parent/guardian giving the school nurse permission to administer medication(s) prescribed by the health care provider.
3. Parents/Guardians shall assume the responsibility for hand-delivering medication in the original container, identified by the pharmacy to the school nurse.
4. The medication shall be kept by the school nurse and administered only by the school nurse.
5. Apart from medications as noted above, the school nurse may administer emergency medication for severe allergic reactions as authorized by the district medical officer. In the event of such an emergency, the school shall make every reasonable effort to contact the parent/guardian.

DOCTOR'S ORDER FOR MEDICATION

To protect the health of_____, it will be necessary for him/her to have medication during school hours, prescribed by me, as follows:

Purpose_____ Dosage and Route _____

Medication_____ Time(s) to be given_____

PHYSICIAN'S OFFICE STAMP

_____
Physician's Signature

_____
Date

REQUEST FROM PARENT

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.

ON EARLY DISMISSAL DAYS OF SCHOOL (PLEASE CHECK ONE):

❒ **I WANT** the School Nurse to administer medication on early dismissal days.

❒ **I DO *NOT* WANT** the School Nurse to administer medication on early dismissal days.

_____ _____
Date Signature of Parent/Guardian

_____ _____
Primary Contact Cell Number Secondary Contact Cell Number