Dunellen Public Schools

Department of Special Services
Dunellen High School
411 First Street
Dunellen, New Jersey 08812
Phone: (732) 968-0885 ext. 45
Fax: (732) 752-3466

Mr. Pio Pennisi, Superintendent
Mrs. Lori MacManus, RN, BSN, CSN, DHS/LMS School Nurse
Ms. Anne North, RN, Faber Nurse

AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION IN SCHOOL FOR ACUTE ILLNESSES

The following section is to be completed by the PARENT/GUARDIAN:

_____ _____
Student's Name Grade

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

_____ _____ _____
Parent/Guardian Signature Telephone Date

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY
AND MUST BE RENEWED ANNUALLY

please turn over→

The following section is to be completed by the PHYSICIAN:

Diagnosis: (check all that apply)

_____Headache

_____Toothache/Dental pain

_____Menstrual Cramps

_____Musculoskeletal Pain

_____Earache

_____ Fever

_____ Other: _____

Medication: (Select one)

_____Ibuprofen _____mg. po q_____hrs prn

_____Acetaminophen_____mg, po q _____hrs prn

_____Other:_____mg q_____hrs prn

List significant side effects:

_____

_____

Any restrictions or limitations:

_____

Date prescribed: _____ Date to be discontinued: _____

_____

Physician's Name Address Telephone No.

_____ _____

Physician's Signature Date

This form must be completed for **all <u>OVER THE COUNTER MEDICATIONS</u>**.
Ibuprofen, and acetaminophen will be provided by the school district.
Parent/Guardian will be notified prior to administration of the medication.