WALL TOWNSHIP PUBLIC SCHOOLS
Release from Physician and Parent for School Nurse to Administer Medication to Student

All medications (whether prescription or over the counter) shall be brought to school by the parent/guardian in the original labeled container and shall be picked up at the end of the period of medication or at the end of the school year. **Prescribed and over the counter medications, including vitamins, all require a written doctor's order.**

Children are not permitted to self-administer any medication in school. (Students needing life saving medication are an exception to this rule, but must have proper documentation from their physician on file in the health room.)

- The Board shall not be responsible for any diagnosis and treatment of student illness.
- The administration of medication to a student during school hours will be permitted only when failure to take such medicine would jeopardize the health of the student, or the student would not be able to attend school if the medicine were not made available to him/her during school hours.
- For purposes of this policy, *medication* shall include all medicines **prescribed** by a physician for the particular student, including emergency medication in the event of bee stings, etc., and all over the counter medications.
- Before **any** medication may be administered to or by any student during school hours, the Board shall require the written request of the parent/guardian who shall give permission for such administration and relieve the Board and its employees of liability for administration of medication.
- **In addition,** the Board requires the written order of the physician (even for over the counter medication) which shall include:
  a. The purpose of the medication;
  b. The dosage;
  c. The time which or the special circumstances under which medication shall be administered;
  d. The length of time for which medications are to be taken. The release must be renewed by the physician and parents annually or when a re-evaluation of the student is indicated;
  e. The possible side effects of the medication.

STUDENTS NAME: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

INSTRUCTIONS REGARDING THE ADMINISTRATION OF MEDICATION: _____

_____

POSSIBLE SIDE EFFECTS OF THE MEDICATION: _____

_____

The school nurse has permission to administer the above medication as prescribed.

DOCTOR'S SIGNATURE: _____

PHYSICIAN'S STAMP: _____

(Form is invalid without physician's stamp)

DATE: _____ PHONE NUMBER: _____

PARENT'S SIGNATURE: _____

DATE: _____ PHONE NUMBER: _____

SCHOOL NURSE'S SIGNATURE: _____ DATE: _____

Written Orders submitted by fax must be **verified by the school nurse**.