

SOUTH BRUNSWICK TOWNSHIP PUBLIC SCHOOLS

South Brunswick High School

750 Ridge Road, Monmouth Junction, NJ 08852
(732) 329-4044

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Main Health Office

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Annex Health Office

ADMINISTRATION OF MEDICATION

Dear Parent/Guardian,

A Medication Order Form must be completed if your child will require medication during school hours. (**Exception:** please see web site for condition specific forms for students with asthma requiring inhalers, allergies requiring Epi-pens, diabetes and seizures)

In compliance with New Jersey Department of Education Guidelines and Regulations, and the South Brunswick Township Public School District Board of Education, any medication which is to be administered during school hours:

1. Must be accompanied by a note (**Medication Order Form – Part 1**) from you giving permission for the nurse to give the medication.
2. Must have a note (**Medication Order Form – Part 2**) from your physician or dentist containing the following:
 - a) Student's name
 - b) Date
 - c) Medication name
 - d) Dosage
 - e) Time to be given
 - f) Diagnosis
 - g) Side effects to be observed
 - h) Length of time order is in effect
(maximum: one school year)
 - i) Physician/Dentist signature
3. Must be in its **original pharmacy labeled container** (ask your pharmacist for a separate bottle for school): **over the counter items also must be in original packaging.**
4. Must be accompanied by a new prescription when there is a change in medication or dosage.

This policy includes **all medication** to be administered in school including over the counter items.

Please review the medication policy below and return the permission (Medication Order) form to the Health Office as soon as possible.

Please feel free to call the Health Office with any questions you may have.

Medication Policy

It is the policy of the South Brunswick School District that the administration of medication to students shall be done **ONLY** in exceptional circumstances where the child's health may be jeopardized without it.

Students are **NOT** permitted to carry any medications in school, with the exception of asthma inhalers and Epi-Pens. For the health and welfare of your child, the school nurse must be notified if either an inhaler or an Epi-pen is required. Inhalers and Epi-pens may be carried by the student and must be labeled with the student's name. Also, the Health Office must receive a completed permission slip (Medication Order Form) from you and your child's physician.

If medication has been prescribed for your child and it needs to be given during the school day, it **MUST** be given to the nurse in the beginning of the school day, it **MUST** be in the original labeled container and it **MUST** be accompanied by written permission and directions from the parent / guardian and physician.

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MEDICATION ORDER FORM

Medication Order Form - must be completed if your child will require medication administration during school hours.
Exceptions - please see our website to obtain condition specific forms for students with asthma requiring inhalers, allergies requiring Epi-pens, diabetes and seizures.

Student's Name: _____ Date of Birth: _____
Grade: _____ School year: _____

Part I - Completed by the student's Parent / Guardian

I hereby request that the school nurse administer the medication as directed by my physician/dentist to my child _____. I will supply the medication in its **ORIGINAL CONTAINER** and will notify the school nurse promptly of any changes.

Please list any medications taken at home including reason for medication and time given: _____

Please list any **allergies**: _____

Additional comments or instructions: _____

Date _____ **Signature of Parent/ Guardian** _____

Part 2 – Completed in full by the student's Physician or Dentist

I certify that it is essential to the health of _____
(child's name)
that the following medication be administered during school hours as directed.

DIAGNOSIS: _____

NAME OF MEDICATION: _____ DOSAGE: _____

MODE OF ADMINISTRATION: _____ FREQUENCY OF ADMINISTRATION: _____

TIME OF ADMINISTRATION: _____ SIDE EFFECT: _____

DURATION OF ORDER: _____ (MAY NOT EXCEED SCHOOL YEAR)

If this medication is to be given on a regular basis, please indicate what needs to be done when the student is on a class trip or on early closing days. **Teaching staff cannot administer medications.**

_____ Student **will not** be taking the medication on a class trip
_____ Administer the medication when the student returns from the class trip.
_____ Circle one: Administer / Do Not Administer the medication on early closing days.

Date _____ **Signature of Physician/Dentist** _____ Telephone _____

Physician/Dentist Stamp: