MEDICATION FORM

Sayreville School District
P.O. Box 997
Sayreville, NJ 08871

School Year ___________

Dear Parent/Guardian:

The taking of medication in school is regarded very seriously. Medication is considered such if it is prescribed by a physician or is an over-the-counter medication, including but not limited to Tylenol (acetaminophen), ibuprofen, cough syrup, etc.

If your child requires medication during school hours, it must be sent in the original properly labeled container and the form below must be completed. Your assistance in adhering to our policies is greatly appreciated.

Pupils may take medication in a building only in the presence of a nurse and at the written request of a parent **and** physician with the following exception:

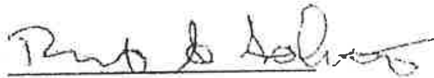
- A pupil may be permitted to self-administer medication for asthma or other potentially life-threatening illness. The child's physician must certify, in writing, that the child has asthma or another life threatening illness and that the child is capable of and has been instructed in the proper administration of the required medication.

Permission is effective for the school year for which it is granted and must be renewed annually, following the above-mentioned process. Prescriptions are valid up to expiration dates.

The school and the Sayreville Board of Education take no responsibility for the diagnosis and treatment of pupil illness. The district shall incur no liability as a result of any injury arising from the self-medication.

School Physician: Dr. Robert Salston

Sincerely,

School Physician's Signature: 

Richard Labbe, Ed.D.
Superintendent

Exhibit 1 - Sample Form

AUTHORIZATION AND CONSENT TO ADMINISTER MEDICATION

Student's Name:______________________________ Grade:______________

Address:______________________________ Teacher:______________

Telephone:______________ Cell Phone:______________

I (we) request authorization and consent to have the school nurse or an appointed faculty member administer medication as prescribed by our private physician to my child while in school. I (we) also hereby release the board of education, the school physician, school nurse and all of their employees from any liability connected therewith.

Date:________ Parent/Guardian Signature:______________________________

Parent/Guardian Signature:______________________________

TO BE FILLED OUT BY THE PHYSICIAN

Name of student:______________________________

Name of medication:______________________________

Diagnosis: ______________________________

Prescribed dosage:______________________________

Route: ______________________________

Circumstances for the administration of the medication?______________________________

____

Specific time of administration:______________________________

How long do you expect this student to be on the medication?______________________________

Side effects that may be expected:______________________________

____

Comments or suggestions:______________________________

I verify that this medication must be administered during school day or during school activity or function in order for student to be able to attend or benefit from the instruction or services being provided by the school district.

Physician's Signature:______________________________

Address:______________________________ Telephone Number:______________

Stamp