

EAST BRUNSWICK PUBLIC SCHOOLS
Student Services

TO: Parents/Guardian of _____
Name of Child

Name of School: _____ Grade: _____

FROM: School Nurse DATE: _____

RE: Authorization for Administration of Medications in School

Administrative policy of the East Brunswick Public Schools requires the school nurse to have the written permission of a child's parent/guardian and physician in order to administer any medication during the school day. (This includes non-prescription medication)

The medication must be given to the school nurse, by an adult, in a pharmacy labeled container which includes the name and the telephone number of the pharmacy, the prescription number, the student's name, directions for administering the medication, and the name of the physician prescribing the medication. No medication is to be kept in the classroom. Information regarding medication will be shared with staff on a need-to-know basis.

Parent will provide a physician's note if this student suffers from a life threatening condition which requires immediate use of an inhaler or pre-filled auto-injector mechanism (Epi-Pen). Student must report to the school nurse to demonstrate they have proper knowledge and use of these medications. Self-management privileges will be revoked if students do not use these medications properly.

Any student whose physician orders a pre-filled auto-injector mechanism (Epi-Pen) for anaphylaxis shall have a volunteer, non-medical designee to administer one dose of prescribed epinephrine via a pre-filled auto-injector mechanism when the school nurse is unavailable. This also pertains to those students who are capable of and have self-medication orders.

I release, indemnify, and hold harmless the Board of Education and its employees against any and all liability for damage or injury arising out of approval of this request.

Please return this form to the school nurse after completed by parent and physician. This request must be reviewed each school year.

I hereby authorize the school nurse to administer his/her medication to:

_____, as prescribed by: _____

Child's Name

Physician's Name - please print
(STAMP NOT ACCEPTABLE)

Parent's Signature

Date

Comments (optional)

EAST BRUNSWICK PUBLIC SCHOOLS
Student Services

PHYSICIAN'S INSTRUCTIONS FOR ADMINISTERING MEDICATION IN SCHOOL

Students Name: _____ **Grade** _____
School _____

TO BE COMPLETED BY THE PHYSICIAN:

Medication for the above-named child is necessary during the school day and should be administered as follows:

Date of Order: _____ Name of Medication _____

Diagnosis: _____

Purpose of medication: _____

Dose: _____ Time: _____ A.M. _____ P.M. _____ P.R.N.

Can a reaction be expected: _____

If so, describe: _____

In the event of a field or class trip, the above named child may do without prescribed medication on that day.
(Effective for this school year only) Yes may omit for trips No may not omit for trips

Student may self-carry and administer inhaler-epipen Yes No Hx: Anaphylaxis: Yes No
Parent will provide an additional inhaler or pre-filled auto-injector mechanism (Epi-Pen) identical to the one the student is authorized to carry which will be retained by the school nurse in accordance with the district medication policy.

I certify that student has been trained in the use of the Inhaler _____ and /or Epipen _____

ASK/ENCORE program - permission for students to self administer inhaler or EpiPen. Yes No

Please note: NO other medications may be self carried or self-administered by the student.

Name of physician (please print): _____

(Signature of physician) STAMP NOT ACCEPTABLE

Address: _____

Phone #: _____ Date: _____

Parent's Signature

Date