READINGTON TOWNSHIP PUBLIC SCHOOLS

Readington Township School District
School Year 2019-2020
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

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

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____

Name of medication:_____

Dose: _____

What time should the daily medication should be given? _____

If medicine is be given "WHEN NEEDED", describe indications:_____

How soon can PRN medicine be repeated? _____

List significant side effects: _____

Any restrictions or limitations: _____

Date prescribed: _____ Date to be discontinued: _____

PLEASE CHECK THE APPROPRIATE OPTION

** **RE: CLASS TRIPS** When a parent or nurse is unable to attend a class trip:

_____ **YES**, the prescribed dose can be withheld on the day of the class trip.
_____ **YES**, the time to be given can be adjusted with the parent/guardian.
_____ **NO**, this medication must be given to the child at the scheduled time.

I verify that this child is free from contagion and this medication is necessary for the student to fully participate in the school educational plan.

_____
Physician's Name /Stamp Address Telephone

_____
Physician's Signature Date

This form must be individually completed for **all prescribed medications**.
Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy.
All medications **will be kept** in a locked storage area.