Readington Township Public Schools **School Year _____**

School Nurse Authorization for RX/OTC Medication Administration

This form is to be completed for all medications other than asthma medications and epinephrine.

*Original copy of this form is required by NJ State law.
*State law requires that medication be renewed each school year.
*Only one medication per form.

Name_____ Grade _____ DOB _____Date _____

Diagnosis _____

Allergies_____

Medication _____

Dosage_____ Time/Frequency _____Route_____

Possible Side Effects _____

MEDICATION ORDER FOR CLASS TRIP DAYS (Please note most trips are full day)
___ Dose may be omitted ___ Dose to be given on return to school.
___ Other (please specify):_____

MEDICATION ORDER FOR EARLY DISMISSAL
___ Omit afternoon dose ___ Maintain original order

***In the event that the student is not given their morning dose at home, the school nurse may give the medication listed above with parental permission*. AM DOSE: _____**

_____ _____ _____
Provider's Signature **Office Stamp** **Date**

Parent/ Guardian Consent for Giving Medication During School

I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of my child.

I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

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.

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