WESTBRIDGE ACADEMY

60 WEST STREET
BLOOMFIELD, NEW JERSEY 07003
(973) 429-8110

PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL 2016-2017

I request that the following medication be administered by the school nurse to the below named student:

STUDENT'S NAME:_____ **DOB:**_____

PHYSICIAN'S NAME:_____ **PHYSICIAN'S TELEPHONE NUMBER:**_____

DIAGNOSIS/PURPOSE:_____

NAME OF MEDICATION:_____ **TIME(S) TO BE GIVEN (MUST BE SPECIFIC):**_____

DOSAGE:_____ **DURATION OF ADMINISTRATION:**_____

POSSIBLE SIDE EFFECTS:_____

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

REQUEST FOR ADMINISTRATION OF MEDICATION INSTRUCTIONS

It is the policy of the school that:

1. The school shall not provide pupils with aspirin or any other medication.
2. Diagnosis or treatment beyond first aid procedure is not within the responsibility of the school and is illegal by non-medical personnel.
3. The administration of medication to pupils shall be done only in exceptional circumstances wherein the child's health may be jeopardized without it, or as in the case of medication being given to modify behavior.
4. Pupils requiring medication at school must have a written statement from the family physician which identifies the diagnosis, the medication, the dosage, the time(s) for administration, and the number of days for which the medication is to be administered.
5. A written statement shall be required from the parent/guardian giving permission for the prescribed medication and relieving the school of responsibility for any possible adverse effects of said medication.
6. Medication must be sent to school in its original pharmacy container appropriately labeled by the pharmacy or physician.
7. Medication is to be held by, and administered only by, the School Nurse.
8. We are not able to send medication home with your child for any reason. Please take out enough medication for weekend and holiday administration at home.

PARENT CONSENT

I hereby request that my child, _____, be administered medication during school hours as prescribed by our family physician. The doctor's written instructions accompany this request.

I understand that the school staff cannot change the administration of any medication (increase/decrease dosage; change times medication is given) without WRITTEN notification from the prescribing physician.

I understand that ultimate responsibility for the administration of any medication is mine. I release the school Board and the school staff from any responsibility for adverse effects due to administration or lack of administration of this medication.

_____
(Signature of Parent/Guardian)

_____ _____
(Date) (Address)

ML:jrd
07/15