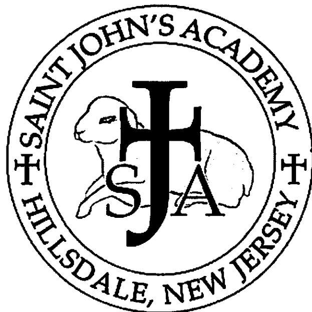
NUR-5



Saint John's Academy

460 Hillsdale Avenue . Hillsdale, NJ 07642 . (201)664-6364

ADMINISTRATION OF MEDICATION IN SCHOOL

The following steps must be taken if your child is in need of <u>**ANY**</u> type of medication during the school day (including Tylenol, Advil, antibiotics, and cold preparations):

1. The health office must have on file a written request from the physician in which he indicates the name, frequency and dosage of the prescribed medication. This includes <u>**ALL**</u> over-the-counter medication.

2. The health office must have on file a written request from the parent in order to administer the medication as prescribed by the physician.

3. The medication must be in the original container, as it is received from the pharmacist. Over-the-counter medication, including Tylenol and Advil, must be in the original container and be labeled with the name of the child and description of dosage.

4. The medication must be kept in the health office.

5. A separate form must be completed for each medication to be administered.

6. Additional forms for parent and physician authorization are attached.

ADMINISTRATION OF MEDICATION

Medication must be in a PRESCRIPTION bottle with a pharmacist's label attached. Over-the-counter medication must be in the original container and be labeled with the child's name.

If you wish the school nurse to administer your child's medication during school hours, we require that this form be completed and returned to the health office. Thank you for your cooperation. **This form must be renewed annually.**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request that the school nurse (or principal's designee) administer medication as prescribed by my child's physician.
Student's name:______________________________ Date of Birth:__________ Grade:______

Teacher/Homeroom:_________________________ Parent/Guardian's home phone:__________

I hereby release St. John's Academy and its employees from any and all liability arising from the administration of this medication.

Parent/Guardian signature:_____________________________________ Date:______________

TO BE COMPLETED BY THE PHYSICIAN FOR EVERY MEDICATION (PRESCRIPTION AND OVER-THE-COUNTER)

Patient name:____________________________________ Diagnosis:_______________________

Medication:___________________________ Dose:_______________ Frequency:___________

Dates for administration – From: ___________________ Through:________________________

If PRN, signs and symptoms for administering medication: ______________________________

Possible side effects: ____

Restrictions (specific): ____

Print M.D. name, address, and phone number: ____

____

M.D. Signature: ___________________________________ Date: ________________________

If you require additional medications, please copy this form or see the school nurse.