CALIFON PUBLIC SCHOOL
6 School Street
Califon, NJ 07830
Phone 908-832-2828 Fax 908-832-6719

School Medication Policy

- No medication can be administered to a student without the written authorization from the parent and physician.
- Written authorization is required for all medications including over-the-counter medications such as Tylenol, Advil, cough medicine, cough drops and medicated skin creams.
- A medication authorization form must be completed by the physician and signed by both the physician and parent.
- If your child needs to receive more than one medication, please feel free to make copies of the form or call the office for additional copies.
- Medication that is brought into school MUST BE TRANSPORTED BY AN ADULT AND IN ITS ORIGINAL CONTAINER.
- If you are bringing in a prescription medication, ask the pharmacist to give you two labeled bottles when you drop off the prescription. With prescription medications, please bring in to school only the amount of medication that will be administered in school so that the medication does not have to travel back and forth from school every day.
- The only medications that students are allowed to carry with them and self-administer are those medications needed for potentially life-threatening illnesses such as inhalers for asthma or epipens for anaphylaxis. The students may carry these medications only when the student is able to demonstrate proper self-administration technique. Self-administration forms need to be signed by the physician and parent then returned to the Health Office.
- All other medications will be kept locked in the Health Office and will be administered to the student at the time designated by the physician.
- The certified school nurse, parent or guardian are the only ones permitted to administer medication to students in school or on class trips.

If you have any questions concerning the school's medication policy, please do not hesitate to call me. The safe handling of medication is an important lesson to our children.

Califon Public School
<u>School Nurse Authorization for RX/OTC Medication Administration</u>

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 ____

<u>MEDICATION ORDER FOR CLASS TRIP DAYS</u> (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**

<u>Parent/ Guardian Consent for Giving Medication During School</u>

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 <u>original pharmacy container</u> 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 <u>N.J.A.C</u>:.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**