

DEMAREST MIDDLE SCHOOL  
DEMAREST, NEW JERSEY

FORM #4  
MEDICATION REQUIREMENT

CHILD'S NAME \_\_\_\_\_ TEACHER \_\_\_\_\_

Will your child have to take any type of medication while on the school trip?

YES \_\_\_\_\_ NO \_\_\_\_\_

If "Yes" is checked above, you must have your doctor complete Section I below and parent sign Section III.

I. DOCTOR'S ORDER – Medication to be given by the SCHOOL NURSE  
(To be completed by physician)

The following medication is to be administered to my patient, \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE/ROUTE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_ LENGTH OF TREATMENT \_\_\_\_\_

SIGNIFICANT SIDE EFFECTS \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

\_\_\_\_\_  
M.D. Name (print)

\_\_\_\_\_  
School Physician Approval

\_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Date

ONLY FOR INHALERS OR EPI PENS

II. DOCTOR'S ORDER – Student "self-administration" of medication Life Saving medications only  
(To be completed by physician)

The following medication is to be self-administered by my patient \_\_\_\_\_. I hereby certify that my patient has a life threatening illness and that my patient is capable of and has been instructed in the proper administration of the required medication.

MEDICATION \_\_\_\_\_ DOSAGE/ROUTE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_ LENGTH OF TREATMENT \_\_\_\_\_

SIGNIFICANT SIDE EFFECTS \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

\_\_\_\_\_  
M.D. Name (print)

\_\_\_\_\_  
School Physician Approval

\_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Date

III. PARENT/GUARDIAN REQUEST AND RELEASE

I request for my child, \_\_\_\_\_, to receive (self-administer) the medication designated above. I have been informed that the school district, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child. I hereby indemnify and hold harmless the Demarest Board of Education, its agents, and employees from any and all claims.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\*\*\*If at all possible, medication should be given at home.

\*\*\*This permission MUST be renewed annually.

## **Demarest Public Schools School Health Services**

### **Administration of Medication During School Hours**

The Board shall not be responsible for the diagnosis and treatment of student illness. The administration of prescribed oral medication should be avoided, but will be permitted when failure to take such medication would jeopardize the health of the student or the student would not be able to attend school if the medicine were not administered during school hours. Medication will be administered only after the following conditions have been met.

1. A written request must be completed and returned to the school nurse by the prescribing physician detailing the name of the medication, diagnosis, dosage, form, time of administration, duration of treatment, side effects, and ramifications of failure to medicate (complete Section I of form: Physician's Authorization).
2. A written request must be completed by the parent/guardian and returned to the school nurse for the administration of medication that are authorized by the physician (complete Section III of form: Parent/Guardian Authorization) relieving the Board of Education and its employees of liability for administration of medication.
3. Permission may be granted to a student for self-administration of medication for asthma or other potentially life-threatening illnesses (i.e.: inhalers, Epi-pens, Glucagon, etc.) provided the Parent/Guardian and Physician's Authorizations are completed including written certification regarding the student's condition and that the student is capable and has been instructed in self-administration of the medication (complete Section II of form: Physician's Authorization).
4. The district shall incur no liability as a result of an injury arising from the self-administration of medication by the student.
5. The medication must be brought to the school nurse in a container properly labeled with the physician's name, child's name, and drug, dose schedule by prescribing physician or pharmacy. The nurse may verify prescribed medication with the physician.
6. Absolutely NO over the counter medications (i.e., Tylenol, Advil, Maalox, etc.) will be administered in school unless ordered by a physician and accompanied by the completed sections of the form (complete Section I and III).