2016-2017
MEDICATION REQUEST FORM

The NJ Department of Education; Office of Educational Support Services, recommends that **ALL MEDICATION (prescription and over the counter OTC)** must be accompanied by written permission from **BOTH** the **PARENT** and **PHYSICIAN**. The ESC follows the recommendation that permission is required from **BOTH PARENT AND PHYSICIAN** for administration of any medication. In order for a student to receive any medicine, including Tylenol or Advil, the nurse needs written permission from both the parent and the physician.

Prescription medication must be brought to school by the parent, unless other arrangements have been made with the nurse. It must be in the original prescription container, labeled with the name of the student, medication, dosage and name of the physician.

Any OTC medication must be brought to school by the parent in the original sealed container and labeled with the student's name. All medication is to be taken home by the parent when it is no longer needed or at the end of the school year. Unclaimed OTC medication shall be disposed of at the end of each school year.

All prescription and non-prescription medications should be provided by the parent/guardian along with: written permission of the child's physician and parent/guardian including the child's name, purpose of the medication, the time at which (or the circumstances under which) the medication shall be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's well being should be sent to school.

NOTE: THE VERY FIRST DOSE OF THIS MEDICATION MAY NOT BE GIVEN AT SCHOOL.

NAME OF STUDENT_____DOB_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM_____TO_____
DATE DATE

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

_____ _____
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT_____ DOB_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM_____ TO_____
DATE DATE

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

NAME OF STUDENT_____ DOB_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM_____ TO_____
DATE DATE

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

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_____ _____
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER

4/1/10 ESC of Morris County