Monroe Township Public Schools

MAPLE GROVE ADMINISTRATION BUILDING
75 E. ACADEMY STREET
WILLIAMSTOWN, NJ 08094
(856) 629-6400 • Fax (856) 262-2499

PARENT/GUARDIAN'S REQUEST FOR IN-SCHOOL MEDICATION

Permission for the administration of medication in school by the school nurse will be given only when the student's attendance depends upon the timely administration of medication in school. Medication will not be administered to a student who is physically unfit to attend school or has a contagious disease. Students who wish to be administered medication by the school nurse must comply with the following:

1. The "Request for In-School Medication" form found below is to be completed by the student's parent/guardian and submitted to the building principal who may grant or deny the request. The principal may consult with the school nurse and school medical inspector prior to making this determination.

2. The attached "Doctor's Request for In-School Medication" is to be completed by the student's physician and submitted to the building principal for approval.

3. All medication must be delivered to the school by the parent/guardian.

4. All medication must be in the original containers, with the prescription information affixed.

5. Any unused medication must be picked up by the student's parent/guardian. Medication will be discarded by the school nurse after reasonable efforts to have the parent/guardian retrieve the medication have failed.

PARENT/GUARDIAN REQUEST FOR IN-SCHOOL MEDICATION

School: _____

Student's Name: _____

Parent/Guardian: _____

Physician: _____

I request that my child be permitted to receive _____
in school as directed by his/her physician. (Name of Medication)

_____ _____
Parent/Guardian's Signature Date

_____ Approved:
Principal's Signature

Disapproved:

_____
Date

The Administration of Medication Policy #5330 was approved by the Board of Education on January 22, 2009.

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DOCTOR'S CERTIFICATION FOR IN-SCHOOL MEDICATION

School Year: September, _____ through June, _____

This student is physically fit to attend school and is free of contagious disease and would not be able to attend school if medication was not available for administration during school hours.

_____ _____
Student's Name School

Diagnosis: _____

1. Does student have any known drug, food or insect allergies? If Yes, please list and indicate previous reactions: _____

   _____
2. Name of Medication: _____
3. The Purpose of Medication: _____
4. Time, Dosage and Route of Medication: _____
5. Possible Side Effects: _____
6. Medication Discontinue Date: _____
7. Special Instructions or Comments: _____

   _____
8. This medication must be administered during the school day or the pupil will not be able to attend school.

   Yes _____ No _____
9. For Pre-filled single dose auto injector mechanisms containing epinephrine:
   - This medication is to be administered for anaphylaxis: Yes _____ No _____
   - This student does not have the capability for self-administration of this medication:

     Yes _____ No_____

_____
Doctor's Phone Number

_____ _____ _____
Doctor's Signature Print Name Date