New Providence Board of Education
356 Elkwood Avenue
New Providence, New Jersey 07974

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

To be completed by parent/guardian before any prescribed or over-the-counter medication, other than epinephrine, may be administered in school. <u>This form does not apply to self-administration of medication.</u>

Student ___________________________________ Class _________________

1. Check the applicable statement:

   _____ I am the parent and legal custodian of the above-named student.

   _____ I am the court-appointed legal guardian of the above-named student.

2. I request the Board's permission for the administration of the following medication ______________________________ to my child by the school nurse or, in her absence, another registered nurse.

3. I consent to the administration of the medication by a school nurse or another registered nurse.

4. I acknowledge my understanding that the Board and its employees and agents shall not be liable as a result of any injury arising from the administration of the medication to my child and that I shall indemnify and hold the Board and its employees and agents harmless against any claims arising out of the administration of the medication.

5. I understand that as a condition of any permission granted, I must provide to the Board a
5 written order signed by my child's physician certifying that my child's health and continuing attendance at school require the administration of the medication and containing the following information:

   - the purpose of the medication;
   - the dosage;
   - the time at which, and any special circumstances when , the medication shall be administered;
   - the length of time for which medication is prescribed; and
   - the possible side effects of the medication.

6. I understand that I must bring the medication to the school nurse in the original, labeled container and that I am responsible for replacing the medication when it expires or when otherwise necessary. I agree to pick up any unused medication at the end of the school year, when the medication becomes outdated, or when the medication is no longer necessary, whichever comes first.

7. I acknowledge that I have been informed that permission for administration of the medication will be effective only for the school year in which it is granted but may be renewed by the Board requirements set forth in this form in accordance with the Board's policy on the administration of medication.

I certify that the above statements made by me are true.

_________________________ DATE

____ SIGNATURE OF PARENT OR GUARDIAN

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PHYSICIAN AUTHORIZATION FOR ADMINISRATION OF MEDICATION

Student ________________________________ Date of Birth ________________

I am the physician of the above-named student. The student is physically fit to attend school and is free of contagious disease. I certify that the student's health and continuing attendance at school require the administration of the following medication during school hours.

Diagnosis for which medication is prescribed: ____________________________________

Medication # 1	Dose	Route of Administration	Timing/Frequency

____

Possible Side Effects

Medication #2	Dose	Route of Administration	Timing/Frequency

____

Possible Side Effects

______________________________ ______________________________

Date Prescribed Discontinue Date

____ ______________________________________

Physician Signature Print or Stamp Physician Name

7/09