WARREN TOWNSHIP RELEASE FROM PHYSICIAN AND PARENT FOR SCHOOL NURSE TO ADMINISTER MEDICATION TO STUDENT

All medications (whether prescription or over the counter) shall be brought to school by the parent/guardians or adult pupil and shall be picked up at the end of the period of medication.

The Board shall not be responsible for any diagnosis and treatment of pupil illness. The administration of medication to a pupil during school hours will be permitted only when failure to take such medicine would jeopardize the health of the pupil, or the pupil would not able to attend school if the medicine were not made available to him/her during school hours. For purposes of this policy, "medication" shall include all medicines prescribed by a physician for the particular pupil, including emergency medication in the event of bee stings, etc., and all over the counter medications. Before any medication may be administered to or by any pupil during school hours, the Board shall require the written request of the parent/guardian who shall give permission for such administration and relieve the Board and its employees of liability for administration of medication. In addition, the Board requires the written order of the physician (even for over the counter medication), which shall include:

A. Name of EACH Medication
B. The purpose of EACH medication
C. The dosage of EACH medication
D. The time which or the special circumstances under which EACH medication shall be administered
E. The length of time for which EACH medication is to be taken. The release must be renewed by the Physician and parents yearly.
F. The possible side effects of EACH medication.

NAME: _____ DOB: _____ WEIGHT: _____

DIAGNOSIS: _____

MEDICATION: _____ Dosage: _____ Frequency/Time: _____

MEDICATION: _____ Dosage: _____ Frequency/Time: _____

MEDICATION: _____ Dosage: _____ Frequency/Time: _____

MEDICATION: _____ Dosage: _____ Frequency/Time: _____

POSSIBLE SIDE EFFECTS OF MEDICATION #1: _____

#2 _____
#3 _____
#4 _____

The school nurse has permission to administer the above medication as prescribed.

PHYSICIAN'S SIGNATURE: _____

DATE: _____ PHONE NUMBER: _____

PARENT'S SIGNATURE: _____

DATE: _____ PHONE NUMBER: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

NO FAXES ACCEPTED FOR LEGAL DOCUMENTS