

BAYONNE PUBLIC SCHOOLS

BAYONNE, NEW JERSEY

PARENT INFORMATION SHEET

MEDICATIONS AND TREATMENT:

Diagnosis and treatment of illness and prescribing of medications are not the responsibility of the school.

SCHOOL POLICY:

1. Treatment of students and school personnel will be limited to first aid procedures only.
2. The school will not provide students with aspirin or other medications.
3. Medication which has been prescribed by private physician may be administered in **exceptional cases** wherein the child's health may be seriously jeopardized without it during school hours.
4. **ONLY THE SCHOOL NURSE MAY ADMINISTER MEDICATIONS. IN THE ABSENCE OF THE NURSE, IT WILL BE NECESSARY FOR THE PARENT TO COME TO SCHOOL TO ADMINISTER THE MEDICATION.**
5. In the event medication is medically indicated to be administered during school hours, to following procedure must be adhered to;

PROCEDURE

- a. The parent attending physician will complete and submit to the school nurse a copy of the required form.
 - b. All requests will be presented to the Chief Medical Inspector for approval.
 - c. When a request is approved by the Chief Medical Inspector, the parent will be contacted by the school nurse and advised to bring to the nurse a **ONE WEEK SUPPLY of the medication in its ORIGINAL CONTAINER.** The label must include: patient's name, prescription number, time and dosage to be administered, and the purpose of the medication.
 - d. The medication will be kept in a locked cabinet in the school's health office.
 - e. The nurse will administer the medication at the prescribed time. In the absence of the nurse, it will be necessary for the parent to come to the school to administer the medication.
6. The school nurse should be advised of medication being taken by a child attending school, particularly those medications which might cause a change in behavior.

BAYONNE PUPPIC SCHOOLS

School: _____

BAYONNE, NEW JERSEY

REQUEST FOR MEDICATIONS TO BE ADMINISTERED BY SCHOOL NURSE

PARENTAL REQUEST:

I, the parent of _____, request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time. I agree to bring a **weekly supply** of the medication in its original container, properly labeled to the school nurse upon approval of my request. I further understand that in the absence of the school nurse, it is **my responsibility** to administer the medication.

Telephone Number

Date

Signature of Parent/Guardian

Address

PHYSICIAN'S STATEMENT

In order to protect the health of _____, it is necessary for him/her to have the following medication during school hours.

Age: _____ Weight: _____

Diagnosis: _____

Medication: _____

Dosage: _____

Time to be Administered: _____

Purpose of Medication: _____

List of Side Effects: _____

I authorize the school nurse to administer the above medication.

Telephone Number

Date

Signature of Physician

Address

REQUEST: Approved / Not Approved /

BY: _____

Referred to Treating Physician

Chief Medical Inspector

For further information

DATE : _____

