HENRY P. BECTON REGIONAL HIGH SCHOOL
120 Paterson Ave., East Rutherford, New Jersey 07073
Phone: (201)-935-3007 Fax: (201)-935-5639

MEDICATION ADMINISTRATION IN SCHOOL-PARENT PERMISSION

(Applies to *any* medication *other than* those permitted by law to be self-administered; e.g. inhalers, Epi-Pens, insulin)

Student Name:_____Grade:____

Date of Birth_____

Students who need medication during school hours must:

-Present a consent form signed by the parent or legal guardian

-Present written orders for prescription and/or OTC medications from the Healthcare Provider which include:

1. **dose, time, and length of administration**
2. **diagnosis/purpose for medication**
3. **any side effects the prescribing health provider wishes to include.**

-Bring the medication in the original bottle, properly labeled by a registered pharmacist if such medication is a prescription drug; in the original container of an over-the-counter (OTC) medication, labeled with student's name.

I, _____, as the parent/legal guardian, give permission for a registered nurse or the school physician to administer the prescribed medication stated on this form to the above named student:

As the parent or legal guardian, I understand that I relieve the Carlstadt-East Rutherford Regional Board of Education and its employees of liability for administration of the above medication. I also understand that the Carlstadt-East Rutherford Regional Board of Education requires the written order of the prescribing physician for such medication.

I also understand that the above medication shall be securely stored and kept in the original labeled container, unless the medication pertains to those allowed by law to be self-administered.

All medication is to be picked up by the end of the school year or at the end of the period of medication, whichever is earlier or the medication(s) will be discarded by the school nurse. **Medication orders must be renewed each school year**.

Parent/Guardian Signature:_____Date:_____

Home Phone_____ Emergency Phone _____

******Authorization for release of information:**
I give my permission for the release/exchange of pertinent information between the school nurse and the licensed prescriber's office by telephone, mail, or electronic exchange regarding all of the medical/medication information described on this form concerning my child.
Circle One ***YES*** ***NO*** ***Parent:Guardian Signature:_____***

************OVER - PLEASE COMPLETE BOTH SIDES***********

AUTHORIZATION BY HEALTHCARE PROVIDER FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

The administration of medication to a student during school hours will be permitted only when failure to take such medication would jeopardize the health of the student or render the student unable to attend school.

The following is to be completed by the prescribing HEALTHCARE PROVIDER:

Student's Name:_____DOB:_____

Name of medication:_____

Student's diagnosis/purpose of medication:_____

_____

Route/Dosage/Time of Administration:_____

How soon can medication be repeated?_____

If medication is to be administered on a ***prn or as needed basis***, describe indications/conditions under which the drug is to be given:_____

_____

Restrictions and/or significant side effects (e.g., labs, physical education, driving):_____

_____

_____

First aid in case of adverse reactions:_____

_____

Date prescribed:_____Date to be discontinued:_____

Other significant information:_____

_____

_____

_____ _____ _____

Healthcare Provider's Signature Date Healthcare Provider's Stamp

****************BOTH SIDES OF FORM MUST BE COMPLETED****************