

HAMILTON TOWNSHIP SCHOOLS DEPARTMENT OF  
STUDENT SERVICES AND PROGRAMS  
OFFICE OF SCHOOL HEALTH SERVICES  
REQUEST FOR ADMINISTRATION OF MEDICATION

TO: Parent/Guardian Date of Birth: \_\_\_\_\_

FROM: School Nurse Height: \_\_\_\_\_ Weight \_\_\_\_\_

RE: \_\_\_\_\_

Student's Name School / Grade/ Teacher/ Room

In response to your request for your student to receive medication during school hours please have the attending physician complete Section One below. After you complete Section Two, please return this form directly to the school nurse.

The administration of medication in the school should be avoided whenever possible. However, when a student's attendance is contingent upon the receipt of medication during school hours, a licensed physician may request it be given by the school nurse. Approval by the Chief Medical Inspector in consultation with the school nurse is required.

Should a medication be prescribed before, during or after meals, please so indicate (rather than at 11:30, example) since students' lunch periods are scheduled different times throughout the district schools.

The medicine must be brought to the school by the parent/guardian in the original container, labeled according to standards. It will be kept in a locked facility.

\*\*\*\*\* **Section One (to be completed by attending physician)** I request that the above named student be administered medication as prescribed in the following:

Diagnosis \_\_\_\_\_ Name of  
Medication \_\_\_\_\_  
Dosage \_\_\_\_\_ Time of  
administering \_\_\_\_\_

Side effects \_\_\_\_\_  
\_\_\_\_\_

Date to begin: \_\_\_\_\_ Date to conclude:  
\_\_\_\_\_

Self-medicate (inhalers, epipens only) **Please**

**Check One:**

- Student instructed and able to self medicate.
- Student is not capable of self medicating.

\_\_\_\_\_  
\_\_\_\_\_  
Name of Physician (Print / type)  
Signature of Physician

\_\_\_\_\_  
\_\_\_\_\_  
Telephone Number Date of  
Signature

\*\*\*\*\*  
**Section Two (to be completed by parent/guardian)**

I request that the certified school nurse administer the above medication to my student as prescribed. I shall deliver the medication to the school in the original container, appropriately labeled by the pharmacy or physician.

**(Please check)**

\_\_\_\_\_ I will attend the field /class trip at my own expense for the purpose of administering medication to my child.

\_\_\_\_\_ I will submit a physician's statement regarding the need not to medicate my child on field/class trip.

\_\_\_\_\_ I request that the child remain at the school.

\_\_\_\_\_ I request that a substitute school nurse attend the field trip to administer medication.

\_\_\_\_\_ I request that my child be medicated on half days.

\_\_\_\_\_ I request that my child not be medicated on half

days.

\_\_\_\_\_  
\_\_\_\_\_ Date Signature of  
Parent/Guardian

\*\*\*\*\* Section Three  
(to be completed by school staff)

\_\_\_\_\_  
\_\_\_\_\_ Date Receipt Signature of  
School Nurse

\_\_\_\_\_  
\_\_\_\_\_ Date Approval by Chief  
Medical Inspector

Reference: N.J.S.A.  
45:11-23

School Health Services Guidelines  
Board of Education Policy/Regulation  
#5330

RETURN TO THE SCHOOL  
NURSE

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08/16