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 l1:30, 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.

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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, epi-pens only) **Please Check One:**

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

_____ _____
Name of Physician (Print / type) Signature of Physician

_____ _____
Telephone Number Date of Signature

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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 physicians 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

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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

SH/ M2
Rev. 6/07