



SPRINGFIELD TOWNSHIP ELEMENTARY SCHOOL

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CRAIG VAUGHN

Superintendent / Principal

STUDENT MEDICATION PERMISSION FORM

In accordance with New Jersey State Law, Springfield Township Board of Education policy states that: *school nurses only are to administer any medication to students.* * This is to be done *only* if medication has been prescribed by the child's physician who has noted diagnosis, medication, dosage and time. This includes any over-the-counter drug. In addition, parent/guardian must sign permission form below and return to the school nurse.

Prescription must be in properly labeled pharmacy containers: over-the-counter medications must be in the original container and accompanied by physician's note. Medication should be brought to school and picked up by designated adult. All medications sent to school will be locked in the nurse's office. *Students are not to carry any medications.*

*State law allows for pupils to self-administer medication for asthma or other potentially life-threatening illnesses provided certain stipulations are followed.

..... TO BE COMPLETED BY PHYSICIAN

Authorization is hereby given for medication to be administered in school to: _____

Name of Student _____ School _____ Grade/HR _____

Medication _____ Diagnosis _____

Dosage _____ Frequency _____ Time to be given _____

*Self administration of medication shall be limited to use of inhalers or epipens. I hereby certify that this student has _____ (a potentially life-threatening condition); has been trained in the use of _____ (name of inhaler/epipen), and is capable of self-administration of this medication for the _____ school year.

Printed Name of Physician

Signature of Physician

Telephone Number

Date

..... TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give permission for the school nurse to administer the above medication (which has been prescribed by my doctor) to my child _____. I shall bring the medication in its original container, properly labeled from the pharmacy. I release the Springfield Township Board of Education and its employees from any liability concerned in the administration of such medicine.

Signature of Parent/Guardian _____ Date _____

*I give my child permission to self-administer _____ (name of inhaler/epipen) in the absence of their parent/guardian or school nurse. I relieve the Springfield Township Board of Education and its employees of any liability, losses, damages incurred by the Springfield Township Board of Education due to self-administration of medication of my child.

Signature of Parent/Guardian _____ Date _____