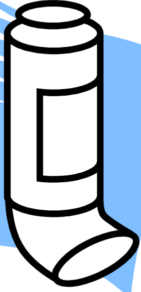
Mount Arlington Public School
446 Howard Boulevard
Mount Arlington, NJ 07856



TO: All Parents

FROM: Jennie Asaro

RE: MEDICATION IN SCHOOL

MAPS
Phone: 973-398-4400
Fax: 973-398-5726

Decker
Phone: 973-398-6400
Fax: Phone: 973-909-7100

In an effort to ensure the safety of our children, we would like to clarify the Mount Arlington School District's Medication policy. **We will need your help in carrying out the following procedures if your child should need medication while in school.**

PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS

Before any **prescription or over-the-counter medication** can be given to a student, the parent/guardian must submit to the school nurse a completed **"Medication Administration Form"** (attached). On this form **parents must complete and sign** their section and your child's **private physician must complete and sign** his/her portion of the form.

- **PARENTS** are to bring the medication to school in the original labeled bottle with a written request for the medication to be given. **STUDENTS ARE NOT PERMITTED TO BRING IN MEDICATION!**

- **ALL** medication (prescription and over-the-counter) will be kept in the nurse's office. Enough medication should be sent in for the entire length of time the child requires it in school (or, in the case of long-term medication, a 30-day supply).

- **THE DOCTOR** must provide a written order for both **prescription and over-the-counter medications** that includes the diagnosis, name of the drug, dosage, time of administration, and its possible side effects.

- **Medication orders must be renewed annually.**

Thank you for your support in following these procedures. If you have any questions or concerns regarding this matter, please do not hesitate to contact me.

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MEDICATION ADMINISTRATION FORM

PHYSICIAN'S SECTION:

Student's Name ______________________________________ Grade _________

was treated for (diagnosis) ____.

I request that the school nurse administer medication prescribed by me for the

period from ___________________ to __________________.
date date

Rx:____

Dosage:_____________________________________ Time:_______________

Side effects:____

Physician's signature:_________________________________ Date:__________

Physician's name:____
(printed)

Physician's phone:__________________________Fax:__________________________

PARENT/GUARDIAN SECTION:

I understand and agree that medication to be administered in school must be delivered in the original container, by myself or another adult, accompanied by this completed and signed form. **UNDER NO CIRCUMSTANCES MAY MEDICINE BE CARRIED BY A STUDENT, EITHER TO SCHOOL OR HOME.**

I give my permission to the school nurse to administer the above prescribed medication.

Parent/Guardian signature:________________________________ Date:_______