REQUEST FOR ADMINISTRATION OF MEDICATION OR USE OF SUCTION,OXYGEN OR OTHER EQUIPMENT IN SCHOOL

Lawrence Township Public Schools - Nurse's Office

Physician, Please note: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment. A separate request is needed for each medication.

NAME OF STUDENT	GRADE	DATE OF BIRTH	**Parent**: The State of New Jersey recommends and the Board of Education requires that if medication must be administered to a student during the school day, **written orders must be given by the prescribing physician.** Permission to administer medication **must be signed by BOTH the physician and the parent/guardian.** **For the safety of all students,** medications are to be **hand delivered** to the school nurse by the parent/guardian in the **original pharmacy labeled container.**
ADDRESS/ZIP			
DIAGNOSIS	REASON MEDICATION MUST BE GIVEN IN SCHOOL		
NAME OF MEDICATION/EQUIPMENT/TREATMENT		DOSE	
TIME(S) TO BE GIVEN AT SCHOOL			
DATE BEGIN	DATE END		*I authorize selected school personnel to administer the indicated medication or to use the equipment or machinery as prescribed by my child's healthcare provider, whose signature appears on this form. I authorize the school nurse to communicate with mv healthcare provider, and my healthcare provider to reply, as needed regarding this medication* *Parent signature: _____* *Telephone number _____* *Emergency number _____*
INSTRUCTION FOR ADMINISTRATION/UTILIZATION			
CAN DOSAGE BE OMITTED **YES** **NO**	CAN DOSAGE TIME BE ADJUSTED **YES** **NO**		
SIDE EFFECTS		IS ANY RESTRICTION ON ACTIVITY NECESSARY **YES** **NO**	
IS STUDENT TAKING ANY OTHER MEDICATIONS - IF YES, NAME OF MEDICATION			
IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME **YES** **NO**			
PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS		**ADDRESS/TELEPHONE**	**In accordance with current school district procedure, the administration of this medication was approved on: _____** Signature of school physician: _____
SIGNATURE AND STAMP OF HEALTH CARE PROVIDER		**DATE SIGNED/STAMPED**	