UNION COUNTY VOCATIONAL - TECHNICAL SCHOOLS

1776 Raritan Road, Scotch Plains, New Jersey 07076-2997
(908) 889-8288 Ext. 405 Fax: (908) 889-1599 www.ucvts.org
Nurse's Office

Request for Administration of Medication

It is the policy of the Board of Education that:

1. Diagnosis of treatment beyond first aid procedures is not the responsibility of this school and is illegal by non-medical personnel.

2. The school shall not provide students with aspirin or any other medication.

3. The administration of medication to students shall be done only in exceptional circumstances wherein the students health may be jeopardized without it, or as in the case of medication being given to modify behavior.

4. Students requiring medication at school must have a written statement from their physician which identifies the diagnosis, the medication, the dosage, the time for administration, and the number of days the medication is to be administered.

5. A written statement shall be required from the parents giving permission for the prescribed medication to be administered and relieved the school of the responsibility for any possible adverse effects of said medication.

6. Parents must assume the responsibility for delivering medication in the original container to the school nurse. Medication is to be held by and administered only by the school nurse.

7. Please complete the **Medication Request Form** (Parent Portion) and have the student's physician complete the **Recommendation of the Private Physician** section. Return the form to school with the necessary medication in the original labeled pharmacy container.

UNION COUNTY VOCATIONAL - TECHNICAL SCHOOLS

1776 Raritan Road, Scotch Plains, New Jersey 07076-2997
(908) 889-8288 Ext. 405 Fax: (908) 889-1599 www.ucvts.org
Nurse's Office

My child, (please print) _____is a student at (please circle one) AAHS, AIT, APA, MHS, or UCT . I request that medication be administered to him/her asprescribed by his/her physician. The physicians written orders accompany this request.

I understand that the ultimate responsibility for the administration of the medication is mine, and I am fully aware that the duties of the school nurses may require her presence at another location at the time the medication is needed. I release the school board and the school staff from any responsibility for adverse effects due to administration or lack of administration of this medication. I will deliver the medication in the original container to the school nurse.

_____ _____
Parent/Guardian Signature Address

_____ _____
Date Town

Recommendation of Private Physician

In order to protect the health of (please print student name)_____,
it will be necessary for him/her to have medication during school hours prescribed by me as follows:

Diagnosis: _____ Medication: _____

Dosage:_____ Time to be given/ for how long: _____

Possible side effects and/or special precautions to be taken:

_____

_____

_____ _____
Physician Signature Physician Stamp

_____ _____
Date Telephone Number