MEDICATION FORM

Sayreville School District
P.O. Box 997
Sayreville, NJ 08871

School Year:_____

Dear Parent/Guardian:

The taking of medication in school is regarded very seriously. Medication is considered such if it is prescribed by a physician or is an over-the-counter medication, including but not limited to Tylenol (acetaminophen), ibuprofen, cough syrup, etc.

If your child requires medication during school hours, it must be sent in the original properly labeled container and the form below must be completed. Your assistance in adhering to our policies is greatly appreciated.

Pupils may take medication in a building only in the presence of a nurse and at the written request of a parent **and** physician with following exception:

> A pupil may be permitted to self-administer medication for asthma or other potentially life-threatening illness. The child's physician must certify, in writing that the child has asthma or another life-threatening illness and that the child is capable of and has been instructed in the proper administration of the required medication.

Permission is effective for the school year for which it is granted and must be renewed annually, following the above-mentioned process. Prescriptions are valid up to expiration dates.

The school and the Sayreville Board of Education take no responsibility for the diagnosis and treatment of pupil illness. The district shall incur no liability as a result of any injury arising from the self-medication.

Sincerely,
School Physician: Matthew Speesler M.D.

School Physician's Signature __ _____

Richard Labbe, Ed.D.
Superintendent

Authorization and Consent to Administer Medication

Sayreville School District

P.O. Box 997
Sayreville, NJ 08871

Student's Name:_____ DOB:_____ Grade:_____

Address:_____ Teacher:_____

Telephone:_____ Cell Phone:_____

I (we) request authorization and consent to have the school nurse or an appointed faculty member administer medication as prescribed by our private physician to my child while in school. I (we) also hereby release the board of education, the school physician, school nurse and all of their employees from any liability connected therewith.

Date:_____ Parent/Guardian Signature:_____

Parent/Guardian Signature:_____

Name of Student:_____

Name of Medication:_____

Circumstances for the administration of the medication?_____

Prescribed dosage:_____ Route of Administration:_____

Specific time of administration:_____

How long do you expect this student to be on the medication?_____

Side effects that may be expected:_____

Comments or suggestions:_____

Physician's Signature:_____

Health Office/Physician Stamp

ADMINISTERING MEDICATION (continued)

Self-Medication Release Form

I, _____ give permission for my child,_____
to self-medicate with _____ as prescribed by _____
(medication) (physician's name)

in emergency situations where the nurse or parent/guardian is not present on-site, off-site, or at an after-school activity.

After reading all of the lines below, please check all of the corresponding boxes:

- ☐ I agree to provide an identical copy of any inhaler/s, epi-pen or other auto-injector, or glucagon which will be stored in a locked cabinet in the original container in the nurse's office.
- ☐ A note from the prescribing physician is attached which includes the dosage and timing of medication and a notation of each instance of administration.
- ☐ Certification by the physician that the student is capable of self-medication and has been instructed on the proper administration of his/her medication.
- ☐ In the event that my child, _____, self-administers medication according to Sayreville Board of Education policy/regulation 5530 Administering Medication, I release the school district of any and all liability.
- ☐ I have received and reviewed the provisions of policy/regulation 5530 Administering Medication.
- ☐ I understand that pupils may take medication in a building only in the presence of a nurse and at the written request of a parent **and** physician with the following exception:
    - A pupil may be permitted to self-administer medication for asthma or other potentially life-threatening illness. The child's physician must certify, in writing that the child has asthma or another life-threatening illness and that the child is capable of and has been instructed in the proper administration of the required medication.

Parent/guardian signature:_____

Date:_____

ADMINISTERING MEDICATION (continued)

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Patient/Student Name:_____ Date of Birth:_____

I hereby authorize_____ [*insert health care provider name & title*]

and_____[*insert name & title of school official*] to exchange health and education information/records for the purpose listed below.

_____[insert address & telephone of school/district]

_____[insert address & telephone of health care professional]

Description:
The health information to be disclosed consists of:_____.
The education information to be disclosed consists of:_____.

Purpose: This information will be used for the following purpose(s):

- ☐ Educational evaluation and program planning
- ☐ Health assessment and planning for health care services and treatment in school
- ☐ Medical evaluation and treatment
- ☐ Other:_____

Authorization:
This authorization is valid for one calendar year. It will expire on _____[*insert date*]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____
Parent Signature Date

_____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.
Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information