



# 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 Union County Vocational-Technical Schools | School Nurse's Office

### 1. CONDENSED BOARD OF EDUCATION POLICY

To ensure student safety and legal compliance, please note the following:

- **CLINICAL SCOPE:** The school does not provide aspirin or any medication. Diagnosis and treatment beyond basic first aid is not the school's responsibility.
- **MANDATORY DOCUMENTATION:** Medication is administered only in exceptional cases and requires **both** a physician's written order and parental consent.
- **SAFE HANDLING:** Parents must deliver medication in its **original pharmacy-labeled container**. Medication is held and administered **strictly by the School Nurse**.

### 2. PARENT/GUARDIAN REQUEST & INFORMED CONSENT

**Student Name:** \_\_\_\_\_ **School:** AAHS | AIT | APA | MHS | UCT | UCCTI

I request that the medication prescribed below be administered to my child.

- **Logistics:** I will deliver the medication in its original container to the School Nurse.
- **Nurse Availability:** I understand that the School Nurse may be at another location during the scheduled time for medication.
- **Liability Release:** I release the Board of Education and school staff from any responsibility for adverse effects resulting from the administration, or lack of administration, of this medication.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**Town:** \_\_\_\_\_

### 3. RECOMMENDATION OF PRIVATE PHYSICIAN

*This section must be completed and signed by a licensed healthcare provider.*

#### DEFINED MEDICAL ORDER

**Diagnosis:** \_\_\_\_\_  
**Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_  
**Administration Time(s):** \_\_\_\_\_ **Duration:** \_\_\_\_\_  
**Side Effects / Special Precautions:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician Name (Stamp):** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_