CHERRY HILL PUBLIC SCHOOLS
Policy for Administration of Medication by Certified School Nurse

In accordance with NJAC 6:29-3.2 and the Nurse Practice Act NJSA 45:11-23, the Cherry Hill Board of Education directs the Superintendent of Schools to establish administrative procedures pertaining to administering prescriptions and non-prescription medications to pupils. The School Nurse may administer medications during the school day.

All medications are administered from the health office by the school nurse.

All medication must be in a prescription bottle with the name of the child and the medication.

All medication must be brought to and from school by the parent or another adult whom the parent designates.

PRESCRIPTION MEDICATIONS

If prescription medication is to be administered in school, all of the following are required:

1. A **written order** (*valid for the current school year*) from the child's physician which includes:
    a. Date of order
    b. Name of student
    c. Diagnosis/Indication
    d. Name of medication to be administered
    e. Dosage, frequency and duration of administration
    f. Time of administration
    g. Route of administration
2. Written parent/guardian permission form releasing the school district and nurse from any liability thereof.

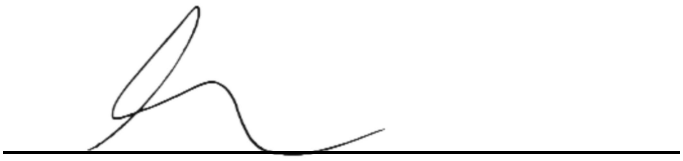
NON-PRESCRIPTION MEDICATIONS

If a non-prescription (over the counter) medication is to be administered in the school setting, **the physician's written order requirement will apply**.

The **only exception** is Acetaminophen/Ibuprofen which can be administered with *signed parental permission* in accordance with established protocols developed by the school physician (See Acetaminophen/Ibuprofen Authorization Form).

The **required permission form** for prescription and non-prescription medication is on the reverse side.

Please contact the school nurse if you have any questions.



Dr. Eric Requa, Chief Medical Inspector
School Year 2026/2027
Revised 4/2020

CHERRY HILL PUBLIC SCHOOLS

MEDICATION AUTHORIZATION FORM

I request the enclosed medication, in the original container be administered to my child and shall release school personnel from all liability. . **PLEASE NOTE: All medication must be brought to and from school by the parent or another adult whom the parent designates.**

Name of Student: _____ DOB: _____

Grade/Team/Graduation Year: _____

Name of Medication: _____

Dosage and frequency: _____

Diagnosis/Indication: _____

Parent's Signature: _____ Date: _____

Primary Phone Number: _____

Secondary Phone Number: _____

TO BE COMPLETED BY THE PHYSICIAN ONLY FOR ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS: The **only exception** is Acetaminophen/Ibuprofen which can be administered with *signed parental permission* in accordance with established protocols developed by the school physician (See Acetaminophen/Ibuprofen Authorization Form)

Name of Medication: _____

Dosage, frequency, duration: _____

Diagnosis/Indication: _____

Reason that medication must be given during the school day:

_____

Comments: _____

Physician's Signature : _____

Physician's Name (print): _____

Phone Number: _____

Physician's Stamp

Date: _____

THIS FORM IS ONLY VALID FOR THE CURRENT SCHOOL YEAR

Revised 2/2025