

TO: All Parents
FROM: School Nurses
RE: Administration of Medication in School

ALL MEDICINE, INCLUDING PRESCRIPTION and OVER THE COUNTER (OTC), must be accompanied by written permission from PARENT and PHYSICIAN.

What this means is that for a student to receive any medicine including Tylenol or Advil, the nurse needs written permission from the parent and the physician. A copy of one of these forms for OTC medication is attached and may be duplicated. There are separate forms for prescription medication and for self administration of inhalers and epipens which are available from the nurse.

The WMRHS Board of Education forbids any pupil from carrying any medication (OTC or prescription) without the knowledge and consent of the administration and the school nurse. Medication shall include all medicines prescribed by a physician including emergency medications i.e.: inhalers and epipens and all non prescription OTC medication.

For the student's convenience, we will stock regular strength Tylenol (acetaminophen) and Advil (ibuprofen), but WE WILL STILL NEED BOTH PARENT and PHYSICIAN PERMISSION to administer them. Any other OTC medication shall be brought to school in the original sealed container and labeled with the child's name. All medication is to be taken home by the parent when it is no longer needed or at the end of the school year.

Prescription medication shall be brought to school by the parent, unless other arrangements have been made with the nurse. It must be in the original prescription container, labeled with the name of the student, medication, dosage and name of the physician.

West Morris Regional School District

PERMISSION FOR (OTC) OVER THE COUNTER MEDICATION

TO BE ADMINISTERED BY THE SCHOOL NURSE

(Parents' and doctor's signatures are required for over the counter medication to be administered.)

Grade _____

PARENTAL PERMISSION:

I request that my child _____ be administered.
Student's name

The following OTC medication by the school nurse:

MEDICATION: Tylenol (acetaminophen) 325mg./tab (2 tabs) _____ Please Check

Advil (ibuprofen) 200mg./tab (1 tab) _____
(2 tabs) _____

Benadryl 25mg./cap (1 cap) _____

Other _____

FREQUENCY: _____

REASON FOR USE: _____

DATE _____ **PARENT/GUARDIAN SIGNATURE:** _____

Permission for medication is effective only for the current school year and needs to be renewed for each subsequent school year.

PHYSICIAN'S PERMISSION:

I hereby authorize the school nurse to administer the above OTC medication.

M.D. NAME (PLEASE STAMP)

M.D. SIGNATURE

ADDRESS/PHONE

DATE