INSRUCTIONS FOR AUTHORIZATION OF MEDICATIONS

Waldwick Board of Education requires the following conditions be met for a student to receive medication in school:

1. Written authorization is required from you and your child's health care provider to administer any medication in school. This includes all over the counter and prescription medications. A nurse or parent/ guardian are the only ones permitted to administer medication in the school setting, unless self-administration is authorized for a life-threatening condition.

2. The medication authorization form is to be completed in full and signed by you **and** your child's health care provider.

3. All medication must be brought to the health office in a current prescription container, appropriately labeled. Please ask the pharmacist for a separate properly labeled container for home use. Medications sent in envelopes and plastic bags **cannot** be accepted.

4. This form is valid for **one school year.** A new medication form must be completed and filed every school year.

5. If during the school year, your child's health care provider determines medication is no longer required, he/she must send this information in writing to the school nurse.

   If the dose of the medication is changed, the health care provider must provide this information in writing to the school nurse.

6. Use one form for each medication.

7. The school physician has signed a written order for the administration of **acetaminophen and ibuprofen.** Therefore, only a parent/ guardian signature is required for these two medications. *Students must provide their own supply of these medications in the original container and packaging.*

EFFECTIVE FOR ONE (1) SCHOOL YEAR

ADMINISTRATION OF MEDICATION BY NURSE

Student's Name_____ **DOB**_____ **Grade**_____

Diagnosis_____

Date Medication Begins_____ **Date Medications Ends**_____

Name of Medication_____

Dose_____ **Route**_____ **Frequency**_____

Side Effects_____

_____

_____

I authorize the nurse to administer the listed medication to my child who is named in the above section. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of the listed medication. I will indemnify and hold harmless the district, school, school nurse and other school employees against all claims arising from the administration of the listed medication. I consent to the communication between the school nurse and the prescribing health care provider necessary to ensure the safe administration of the listed medication.

Name of Health Care Provider (PRINT)_____

Signature of Health Care Provider_____

Address_____

_____

Phone_____ **Date**_____

Signature of Parent/ Guardian_____

Date_____

EFFECTIVE FOR ONE (1) SCHOOL YEAR