PARSIPPANY TROY-HILLS TOWNSHIP SCHOOLS

REQUEST FOR ADMINISTRATION OF MEDICATION

My child ________________________________, date of birth _____________, may be in need of _________________________________ medication during school hours/school sponsored events. I am requesting that the above medication be administered to my child as described in the written Health Care Provider's order, and according to Parsippany Troy-Hills district policy.

This request is valid for the __________________ school year only.

____________________________________ ______________

Principal's Signature Date

____________________________________ ______________

Nurse's Signature Date

____________________________________ ______________

Parent's Signature Date

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

MEDICATION AUTHORIZATION

Date____________________

Dear Parent/Guardian:

You have indicated that (Name)____

(Grade)________________________ is in need of medication during school hours.

It is our policy to have written permission. Please have your physician complete and return to the school nurse.

1. Pupil's name ____
2. Diagnosis ____
3. Name of medication ____

   PLEASE NOTE: An order for epinephrine may be administered by a non-medical trained delegate who is authorized to administer epinephrine ONLY. As such, antihistamines or other medications cannot be given by the delegate. Please take this into consideration when writing your order. If you have any questions in this regard, please call the school nurse listed below. Thank you.

4. Dosage of medication ____
5. Route ____
6. Time to be given ____
7. Special instructions ____
8. Side effects ____
9. Signature of physician ____
10. Physician (Please print, type or stamp) ______________________________

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Fax No. Date

Please submit this information as soon as possible, so that the proper schedule can be maintained. If there is any change during the course of this prescribed medication, please notify the school nurse in writing.

Very truly yours,

______________________________ ______________________________

School Nurse Parent's Signature

School ________________________ ______________________________

Date

Phone No. _____________________

SN# 3
3/16