WALL TOWNSHIP PUBLIC SCHOOLS
REQUEST FOR MEDICATION ADMINISTRATION

In accordance with New Jersey State Law 6A: 16-2.1(a) 2, Wall Township Board of Education policy states that: ***school nurses only*** are to administer ***any*** medication to students. * This is to be done ***only*** if medication has been prescribed by the child's physician who has noted diagnosis, medication, dosage and time. This includes any over-the-counter drug. In addition, parent/guardian must sign permission form below and return to the school nurse. The permission form must be updated **every school year**.

Prescriptions must be in properly labeled pharmacy containers: over-the-counter medications must be in the original **sealed** container and accompanied by a physician's note. Medication should be brought to school and picked up by a designated adult. If your child is approved to self administer epinephrine or an inhaler, an additional, identical inhaler or epinephrine auto-injector must be provided to the school nurse and kept in the health room.

I understand that the district and its employees or agents shall have no liability as a result of any injury arising from the administration of the medication listed below; and shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of the medication.

If your child has a food allergy, asthma, or seizure disorder, this form must be filled out for each medication in addition to action plans that have been developed for those medications. They are available from the nurse or on the Wall Public School website.

Authorization is hereby given for medication to be administered in school to:

Student_____Grade_____

Date of Birth_____ Teacher_____ Room #_____

Diagnosis_____

Medication_____

Dosage_____Frequency_____ Time to be given_____

In the event of school trips, student may skip medication dose for that day: YES____ NO_____

Signature of Physician*_____ Date_____

Physician's Printed Name:

_____

Phone #_____

***Physician's Stamp here:**

Signature of Parent_____ Date_____

Signature of School Nurse_____ Date_____

Signature of Principal_____ Date_____