

REQUEST FOR ADMINISTRATION OF AS NEEDED MEDICATION IN SCHOOL

SECTION 1 - STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
 Homeroom Teacher: _____ Grade: _____
 Parent Name: _____ Parent Name: _____
 Daytime Phone: _____ Alternate Phone: _____
 List Students allèrgies: _____
 List other medication student is taking: _____
 Diagnosis: headache, muscle ache, fever, discomfort, pain, inflammation, other: _____

SECTION 2 - MEDICATION INFORMATION

1. Name of Medication: Tylenol (Acetaminophine) Motrin (ibuprofen)
 2. Dose: per package instructions Time (s) to be given: as needed every 4-6 hours
 3. Route: Orally Inhaled Injected Other: _____
 4. School Year: _____
 OVER THE COUNTER MEDICATION MUST BE GENERIC ACETAMINOPHEN OR IBUROFEN IS AVAILABLE IN THE HEALTH
 SUBMITTED TO THE NURSE BY THR PARENT/GUARDIAN OFFICE. IF NEEDED.
 (ADULT) UNOPENED.

SECTION 3 - CONSENT

* The nurse will administer Benadryl (diphenhydmine) and/or epi-pen (epinephrine) per physician standing order for severe allergy (not seasonal allergies) or anaphylaxis.
 * The nurse will administer medication in the health office when it is necessary to support student health and safety in school.

Date: _____ Physician Signature: School Physician Standing Oder on File
 Physician Name (Stamp/Print): Dr. Richard Bezozo, Care Station, Linden, NJ 07036

I REQUEST THE NURSE ADMINISTER THE ABOVE MEDICATION

Date: _____ Parent/guardian Signature: _____
 Print Name: _____ Relationship: _____

REQUEST TO ADMINISTER MEDICATION TERMINATES AUTOMATICALLY AT THE END OF SCHOOL YEAR.

Please return this form to: The School Nurse. Phone: 609-584-1800 ext 229 Fax: 609-584-6242 or 609-584-6166