

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION UNDER THE SUPERVISION OF THE SCHOOL NURSE

School _____ Date _____

Name of Student _____ Grade _____

Home Room Teacher _____

Medication shall not be administered to a student at school or school functions except in cases where a student's physician has determined that it must be given during the school day.

As the parent/guardian of the above named student, I hereby request that the school nurse, or other licensed registered nurse or physician, supervise the administration of medication to my child, in accordance with the written orders (see Form #2) of Dr. _____ who has determined that the medication must be given during the school day.

I hereby acknowledge that the Middlesex Public School District shall incur no liability for this administration of medication and hereby indemnify and hold harmless the Middlesex Board of Education and its employees or agents from any claims arising out of such administration of medication.

Signature of Parent/Guardian Printed Name

Address _____

Date _____ Phone (Home) _____ (Work) _____

This completed form must be brought to the school nurse by the parent/guardian or adult pupil with the written order of the student's physician and the medication in the original container appropriately labeled by the pharmacy or physician.

MIDDLESEX PUBLIC SCHOOLS

PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF MEDICATION TO A STUDENT DURING SCHOOL HOURS

Medication shall not be administered to a student at school or at school functions except in cases where a student's physician has determined that it must be given during the school day.

Name of Student _____

Name of Medication _____

Diagnosis _____

Dosage _____

Time at which, or special circumstances under which the medication shall be administered _____

Length of time for which the medication is prescribed _____

*** PLEASE CHECK ONE ***

- ____ Student does not require this medication to be administered on any class trip.
 ____ Student requires medication to be administered on all class trips, approved person must attend trips.
 ____ Time of administration may be adjusted for class trips.
 ____ Student unable to self-administer and may require emergency medication, i.e. inhaler or epi-pen, approved person must attend.

 Signature of Physician Date

Printed Name of Physician _____

Address _____ Telephone # _____

This completed form must be brought to the school nurse by the parent/guardian or adult pupil with Form #1, the parent/guardian's request for the administration of medication during school hours, and the medication in the original container appropriately labeled by the pharmacy or physician.