Daily/PRN **Attachment A**

WASHINGTON TOWNSHIP PUBLIC SCHOOLS

REQUEST FOR PUPIL MEDICATION TO BE TAKEN AT SCHOOL

The administration of medication to or by any pupil will be permitted only when failure to take such medication would jeopardize the health of the pupil or the pupil would not be able to attend or benefit from his/her educational program. Medication includes all prescriptions and patent medications (over the counter). Washington Township Public Schools requires both physician and parent permission to administer all medication, including patent (over the counter) medication.

Note to Parent/Guardian: All medication(s) whether patent or prescribed shall be provided to the school nurse by the parent/guardian in the original container. In the case of prescription medication, the original container must have affixed the current prescription labeling as applied by the pharmacy.

Authorizations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the school's Health Office before any medication can be administered.

SECTION A: Parent Request and Consent (To be completed by *Parent/Legal Guardian*)

PLEASE PRINT:

Pupil's Name: _____ School: _____

Parent's/Guardian's Name: _____

Address: _____

Home Phone #: _____ Parent's/Guardian's Work Phone: _____

PARENT'S CONSENT AND SIGNATURE

I, _____ (Name of Parent/Legal Guardian), request that my child, _____, be assisted in taking the medication(s) described above at school, as authorized by me and my physician.

_____ _____

Parent/Guardian Signature Date

See back of page for information to be completed by physician

<u>SECTION B</u>: Physician's Certification (To be completed by the *Physician*)

Physician: _____

Diagnosis for which medication is given: _____

Name of medicine: _____

Form (oral, injection): _____

Dose: _____

If given daily, at what time? _____

If given when needed, describe indications. _____

How soon can it be repeated? _____

Are there significant side effects? _____

Length of time this treatment will continue? _____

Other significant information: _____

I certify that the above statements are true and that the pupil is physically fit to attend school and is free from contagious disease. He (she) would not be able to attend school if the medication is not administered during school hours.

_____ _____

Physician Signature Date

Affix physician's official stamp here: