

Alloway Township School
PO Box 327
43 Cedar Street
Alloway, NJ 08001
(856) 935-1622 / FAX (856) 935-3017

Kellie Whelan, RN CSN
School Nurse
(856) 935-1622, ext. 200

Dear Parent / Guardian,

A school policy regarding the administration of medication to a pupil during school hours was adopted November of 1986. If at all possible, medication should not be given at school. However, if it is necessary, there are several things that are *required* to be done before any medication (prescription or over-the-counter) may be administered to or by any pupil during school hours.

They are:

1. A written request by the parent / guardian which gives permission for such administration and relieves the board and its employees of liability for administration of same medication (a form is available from the school nurse if desired).
2. A written order from the prescribing physician which must include:
 - a. the type of medication
 - b. the purpose of the medication
 - c. the dosage
 - d. the time and/or special circumstances under which the medication shall be administered
 - e. the length of time for which the medication is prescribed, and
 - f. the possible side effects of the medication(a form is available from the school nurse for the physician to complete if desired)

The medication must be brought to school in its original container by a parent or guardian. The medication will be kept in the health office in a locked cabinet. If I am absent unexpectedly and a substitute nurse is unavailable, you will be notified that the medication will not be given.

Thank you for your cooperation in this matter. If you have any questions or concerns, please feel free to contact me at 935-1622, ext. 200.

Sincerely,

Kellie Whelan, RN CSN
School Nurse

Alloway Township School
PO Box 327
Alloway, New Jersey 08001
856-935-1622, ext. 200

Parent Permission Form

Date _____

I give permission for the school nurse to administer the following medication to my child, _____ . I relieve
(Name of the Child)
the Alloway Township School Board of Education and its employees of liability for administration of the medication.

_____ should be given

(Name of the Medication and Dosage)

at _____ from _____

(Time)

(Date of First Administration)

to _____ .

(Date of Last Administration)

(Signature of Parent/Guardian)

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Physician's Order Form (please complete all areas)

Medication Order

Patient's Name _____

Diagnosis _____

Name of Medication _____

Dosage _____

Time to be Given _____

Major Side Effects _____

- The medication may/may not be omitted when the patient is on a school sponsored field trip.
- The medication may / may not be omitted when the patient is on a school sponsored field trip only if the parent or a substitute nurse is unable to go.

Other information _____

Prescribing Physician's Signature (no stamp please) _____ Date

Prescribing Physician's Printed Name _____ Tele. Number

Use your own discretion re: records being FAXed and Confidentiality Laws. Thank you!