AARON DECKER SCHOOL
98 Decker Road
Butler, NJ 07405
Telephone: (973) 492-2037
Fax: (973) 492-8679
www.butlerboe.org

James Manco
Principal

REQUEST FOR MEDICATION ADMINISTRATION BY A SCHOOL NURSE

Student's Name__________________________ Date of Birth______________________

Parent/Guardian's Name____________________ Telephone Work #__________________

Home#_____________ Cell#__________

Date________________

To Be Completed by Physician:

I certify that the above named student has the illness specified below, is physically fit to attend school and is free of contagious disease. I further certify that the student will not be able to attend school if the medication is not administered during school hours.

Name of Illness____

Name and Purpose of Medication____

Prescribed Dosage and Time to be Taken____

Date and Time When Medication Should be Discontinued__________________________

Possible Side Effects____

__________________________________ __________________________________
Physician's Name (Print) Physician's Signature

__________________________________ __________________________________
Telephone Number Date

To Be Completed by Parent/Guardian:

The School Nurse is requested to administer to __________________________________
Student's Name

the medication prescribed by the physician listed above.

____
Signature of Parent/Guardian

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AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

PLEASE COMPLETE, SIGN AND RETURN TO NURSE

Student______________________________ Date__________________________

Date of Birth__________________________ Grade_________________________

As parent/guardian of the above named student, I hereby authorize the release of pertinent medical information to be exchanged among appropriate professional staff involved in the care of the above student. This information will only be shared on a "need to know" and confidential basis. This consent is valid for the ___________ school year and is intended to allow the staff to better serve my child.

____
Signature of Parent/Guardian

____
Home Number

____
Cell Number

____
Work Number

____
Karen Lomascola, RN
Aaron Decker School Nurse

AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION

Date____________________

To be completed by Parent/Guardian:

I/We hereby authorize the Butler Board of Education to allow my/our child_____________ to self-administer the medication as described on the previous page. I/We acknowledge that the Butler Board of Education and its agents and employees will incur no liability as a result of any injury arising from the self-administration of medication requested herein. We hereby agree to indemnify and hold harmless the Butler Board of Education, the Butler School District, its agents and employees against any claims arising out of the self-administration of medication requested herein.

We will notify the school nurse if this medication is no longer required of self-administration is no longer directed by the physician. We understand that permission for self-medication is effective only for the school year for which it is granted, and that such permission may be renewed for each subsequent school year only upon the submission of a completed request form each year.

________________________________	________________________________
Mother	**Father**
________________________________	________________________________
Guardian	**Guardian**