

CHERRY HILL PUBLIC SCHOOLS
Cherry Hill, New Jersey

POLICY FOR ADMINISTRATION OF MEDICATION
BY CERTIFIED SCHOOL NURSE

All medications are administered from the health office by the school nurse.

All medication must be in a prescription bottle with the name of the child and the drug.

It is necessary for the well being of your child that following an illness, the child does not return to school until his/her temperature is normal for 24 hours and other symptoms have subsided.

PRESCRIPTION MEDICINES

If prescription medication is to be administered in school, all of the following are required:

1. A written order from the physician
OR
A pharmacy label on the medication, which should be verified by the school nurse, and must include the following:
 - A. name of pupil
 - B. name of medication
 - C. dosage
 - D. physician's name
 - E. date

2. Written parent/guardian permission form releasing the school district and school nurse from any liability thereof.

PATENT MEDICINE

If a non-prescription medication (over the counter) is to be administered in a school setting, the requirement for prescription medication will apply.

The required permission form is printed on reverse side.

Please contact the school nurse if you have any questions.

Date: _____

09/06

Dr. Jacqueline Kaari
Chief Medical Inspector

CHERRY HILL PUBLIC SCHOOLS
Cherry Hill, New Jersey

I request the enclosed medication, in the original container, to be administered to my child and shall release school personnel from all liability.

Name of Child: _____ Date of Birth: _____

Name of Medication: _____

Dosage: _____

Purpose: _____

Signature Parent/Guardian: _____ Phone: _____

TO BE FILLED IN BY SCHOOL NURSE ONLY:

Prescription #: _____ Date: _____ Pharmacy: _____

Pharmacy Phone: _____ Medication: _____

TO BE FILLED IN BY PHYSICIAN ONLY:

Name of Patient: _____

Name of Medication: _____

Date of Prescription: _____

Dosage: _____

Purpose: _____

Comments: _____

Name of Physician: *(printed)*: _____ Signature: _____

Physician's Phone: _____ Date: _____

NOTE: Include medication prescribed by a physician and all "over the counter" medication.