

June 7, 2011

Dear Parent/Guardian:

**ALL MEDICATION INCLUDING PRESCRIPTION and OVER-THE-COUNTER (OTC) must be accompanied by written permission from PARENT and PHYSICIAN.**

New Jersey State rules and regulations have prompted these mandates.

For a student to receive any medication, including Tylenol and Advil, the nurse must have written permission from the parent and the physician. Enclosed you will find the required forms for OTC and prescription medications.

**Students are forbidden from carrying any medication (OTC or prescription) without the knowledge and consent of the administration and the school nurse. Medication shall include all medications prescribed by a physician including emergency medications, i.e. inhalers, EpiPens and all non-prescription medications.**

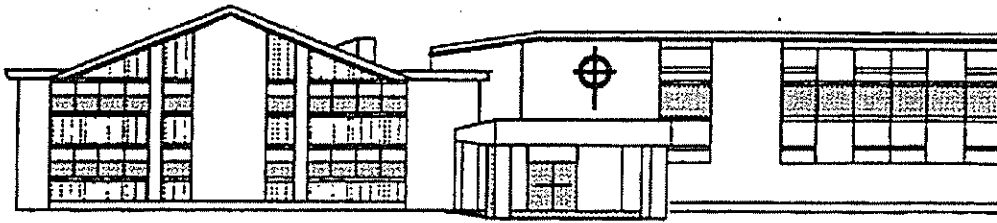
For the student's convenience we will provide Tylenol, Advil, Motrin, Benadryl, Dimetapp and Robitussin, but we still need both parent and physician permission to administer them. Any other OTC medication must be brought to school in an original sealed container and labeled with the child's name. All medication is to be taken home by the parent when it is no longer needed, or by the end of the school year.

Prescription medication shall be brought to school by the parent unless other arrangements have been made with the nurse. It must be in the original prescription container, and labeled with the name of the student, medication, dosage and name of the physician.

If you have any questions, please call the school at 973-543-7474, ext 1.

Sincerely,

Cecilia Fields, R.N.



**ST. JOSEPH SCHOOL**

8 West Main Street  
 Mendham, N. J. 07945  
 Phone: (973) 543-7474

Accredited by Middle States Association of  
 Colleges and Schools

**OVER THE COUNTER (OTC) MEDICATION FORM - 2011/2012 SCHOOL YEAR**

This Form is effective for **ONE SCHOOL YEAR ONLY**

**PARENTAL PERMISSION: (MUST BE ACCOMPANIED BY PHYSICIAN SIGNATURE)**

I request that my child \_\_\_\_\_ be administered  
 (Student's Name)

the following OTC medications by the school nurse:

Medication	Strength	Indicate Dose	Indicate Frequency
Tylenol Junior	160 mgs		
Tylenol Regular	325 mgs		
Tylenol Extra Strength	500 mgs		
Motrin Junior	100 mgs		
Advil Regular	200 mgs		
Benadryl	12.5 mgs		
Dimetapp Cold & Allergy			
Robitussin DM			
Other (Specify)			

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICIAN PERMISSION:**

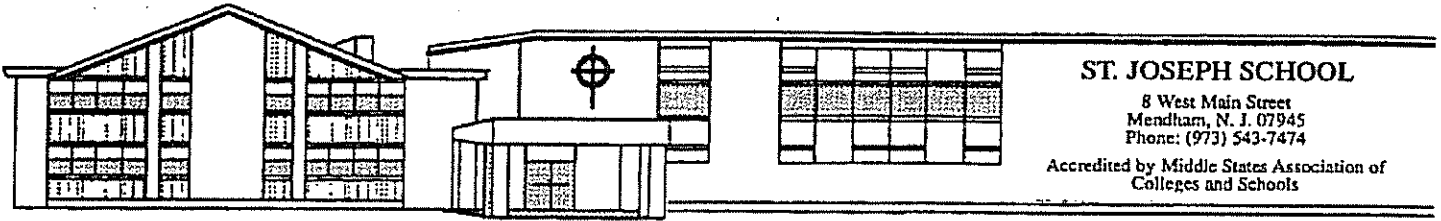
I hereby authorize the school nurse to administer the above OTC medications.

\_\_\_\_\_  
 (MD Name)

\_\_\_\_\_  
 (MD Signature)

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 ADDRESS/PHONE



**PRESCRIPTION MEDICATION FORM – 2011 / 2012 SCHOOL YEAR**

This form is effective for ONE SCHOOL YEAR ONLY

**PRESCRIPTION MEDICATIONS (to be completed by physician)**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
Allergy to: \_\_\_\_\_  
Name & purpose of medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Time to be administered: \_\_\_\_\_  
Length of time medication must be taken: \_\_\_\_\_  
Possible side effects: \_\_\_\_\_

Due to the nature of his/her medical condition, this student has permission to carry:

- A prescription inhaler, and/or
- An epinephrine injection kit

**IF AN ANAPHYLACTIC REACTION OCCURS, THE FOLLOWING WILL BE CARRIED OUT:**

1. ADMINISTER: \_\_\_\_\_  
Medication / dose / route
2. CALL RESCUE SQUAD: \_\_\_\_\_
3. CALL: Mother: \_\_\_\_\_ Father: \_\_\_\_\_ or emergency contact
4. CALL: Dr. \_\_\_\_\_ at \_\_\_\_\_

**If the nurse is not on premises, non-medical trained school personnel will administer epinephrine injection.**

As parent/guardian of the above named student I understand that if the procedures specified in N.J.S.A. 18A:40-12.5 are followed, the nurse, district, nonpublic school and/or service provider shall have no liability as a result of injury arising from the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to the student and shall indemnify and hold harmless the nurse, district, nonpublic school, service provider and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to the student.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date