FORT LEE SCHOOL #3
HEALTH OFFICE
2405 Second Street
Fort Lee, NJ 07024
Tel: 201-585-4640 x3502 Fax: 201-585-1488
Email: ablee@flboe.com

Important Notice

School nurse will NOT administer any medication (including over-the-counter cough drops, eye drops, antibiotics, prescription topical, etc.) to students unless they have received a medication form properly completed and signed by the doctor and parent; and the medication has been received in an appropriately labeled container. In fairness to those giving the medication and to protect the safety of your child, there will be no exception to this policy.

The form below is necessary in order for your child to receive their REQUIRED medication for this school year.

- **Request for Giving Medication At School Form** completely filled out and signed by you AND your child's physician (Form 02-D-18)
- Unexpired medication in the original box with pharmacy label.

If you have any questions about this policy or other issues related to the administration of medication in the schools, please feel free to contact me.

Thank you for your cooperation.

Regards,
Aben Lee, RN, MSN
School #3 Nurse

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

REQUEST FOR GIVING MEDICATION AT SCHOOL
FORM 02-D-18

This form is required for all over-the-counter and/or prescription medication(s) to be administered during school hours. The medication(s) will be supplied by the parents and brought to the school nurse in the original container appropriately labeled by the pharmacy and physician. **All medication must be picked up at the end of the school year.**

Student's Name: ______________________________ Date of Birth: __________

Allergies: ______________________ Grade: ______ Current Weight: __________

Diagnosis/Medical Condition: ______________________________

Name of Medication: ____________________ Dose to be administered: __________

Route: ________ Time to be administered: __________________ am/pm (please circle)

Possible side effects of medication: ______________________________

Intervention to be rendered for an adverse reaction: ______________________________

____

Dates to be dispensed (Please check): ☐ School year _____ to ______ ☐ Half days ☐ Field Trips (including overnight trips) ☐ Other prescribed time period: ________________

x ______________________________ PHYSICIAN SIGNATURE

______________ DATE

x ______________________________ PHYSICIAN PRINTED NAME

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

This section is to be completed by the Parent/ Legal Guardian

Please initial the following:

- I hereby give the school nurse/school physician permission to administer the above stated medication. Initial: __________
- I also, give the school nurse/school physician permission to contact my child's physician regarding the ordered medication, as needed. Initial: __________

______________________ Parent/ Guardian Signature

______________________ Emergency contact number

______________ Date

Received by school and reviewed by ______________________________ **Name** **School Nurse-teacher** **School Doctor**

On ____________________. **Date**