Galloway Township Public Schools
101 South Reeds Road
Galloway, NJ 08205
(609) 748-1250
http://www.gtps.k12.nj.us

PERMISSION TO ADMINISTER MEDICATION

Dear Parent/Guardian and Doctor:

It is preferred that any medication, whether prescription or non-prescription, be given before or after school hours whenever possible. However, if it is essential that the student receive the medication during school hours we will need you to provide the following information. Please note that there is a section to be completed by the physician on the front and a section to be completed by the parent/guardian on the reverse side. **This form is valid for the current school year only.**

TO BE COMPLETED BY A PHYSICIAN

Student's Name _____ Date of Birth _____ Grade _____
Medical diagnosis _____
Name of medication _____
Dosage _____ Route _____
Time _____ Frequency _____
List indications for use _____
Side effects _____
Duration of order _____
List other medications child is on which may enhance, alter or impact this medication _____

For Non-Emergency Medications:

May withhold dose for field trips (School nurses **<u>are not</u>** in attendance on field trips to administer medications and teachers are not permitted to administer medication)	YES	NO

For Emergency Medications:

May be given before gym/exercise	YES	NO
May repeat medication after activity involving exercise	YES	NO
Physical activities restricted	YES	NO
May self-administer for asthma or another potentially life-threatening illness under adult supervision	YES	NO
Is capable of and has been instructed in the proper method of self-administration of medication	YES	NO
Parent will accompany child on field trip to administer medication	YES	NO

Comments_____

_____ _____
Physician/Health Care Provider's Signature Date

_____
Physician/Health Care Provider's Printed Name, Address, Phone Number

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PERMISSION TO ADMINISTER MEDICATON

Dear Parent/Guardian:

Please complete the section(s) below to allow your child to receive medication while they are in school. Please note that the lower section is for self-administration of medication for asthma or potentially life threatening illnesses **ONLY**.

TO BE COMPLETED BY PARENT/GUARDIAN

PARENT PERMISSION TO ADMINISTER MEDICATION

I request and grant permission for the school nurse to administer medication to my child, _____ as prescribed by his/her physician as indicated on the reverse side this form and as per the policy of the Galloway Township Board of Education and State law. I understand that medication is to be brought to school by myself in the original prescription bottle/box labeled properly by the physician or pharmacist.

_____ _____

Parent's/Guardian's Signature Date

_____ _____ _____

Phone Numbers (home) (work) (cell)

PUPIL SELF ADMINISTRATION OF MEDICATION

The Board of Education shall permit self administration of medication for **asthma or other potentially life threatening illnesses** by pupils in grades 1 through 8, both on school premises during regular school hours and off site or after regular school hours when a pupil is participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. Life threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequel that may indicate the potential loss of life (i.e. adrenaline injection in response to anaphylaxis) See Policy 5141.21

My child, _____ has my permission to administer his/her own medication _____ for **asthma or other potentially life-threatening illnesses** both on school premises during regular school hours and off-site or after regular school hours when they are participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. I acknowledge that the Galloway Township Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I indemnify and hold harmless the District and it's employees or agents against any claims arising out of self-administration of medication by my child.

_____ _____

Parent's/Guardian's Signature Date

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