Hopewell Valley Regional School District
Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

The Hopewell Valley Regional School District permits the administration of medication to a student during school hours only when the student's physician and/or dentist/orthodontist certifies in writing that the administration of medication during school hours is essential to the health of the student. The parent/guardian must provide a written request for the administration of medication in school.

PART I – TO BE COMPLETED IN FULL BY STUDENT'S PHYSICIAN OR DENTIST

I certify that it is essential to the health of _____ that the following medication be administered during school hours as directed. Any alteration to this order will occur only with written directions from the prescribing physician.

Diagnosis: _____

Name of medication: _____

Dosage: _____

Time of administration during school hours:* _____

* Whenever possible, non-emergency medication should be scheduled during the child's lunch.

Medication may be given during lunch YES NO

Other : _____

* Administration during field trips:

a. Medication may be waived YES NO

b. Medication may be given when student returns to school YES NO

Side effects, if any: _____

Length of time the order is valid (may not exceed school year): _____

Name of physician/dentist (type or print): _____

Telephone number: _____

_____ _____
Signature of Physician Date

PART II – TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I hereby request that the school nurse administer the above medication as directed by my physician to my child _____. I will supply the medication in its ***original container*** and will notify the school nurse promptly of any change. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications.

I hereby relieve the Board of Education and its employees of liability for administration of the prescribed medication.

_____ _____
Signature of Parent / Guardian Date