Office of the School Nurse

Secaucus High School/Secaucus Middle School

201-974-2026

Dear Parent/Guardian:

Please be advised that, effectively immediately, the School Nurse will no longer provide any type of medication for students, such as Tylenol or Ibuprofen.

If you feel your child will need medication for headaches, cramps, allergy symptoms, etc., it will be necessary for you to obtain, from your child's physician , a Medication Form (enclosed). In addition, you must supply this medication for your child, which will be maintained in the Nurse's Office.

At no time should a student have any medication with them **without** a physician's order.

If you have any questions, please feel free to contact me at 201-974-2026.

Thanking you in advance for your cooperation.

Very truly yours,

Kathy Gerbasio, RN
School Nurse

Secaucus High School *Secaucus Middle School*
11 Millridge Road, PO Box 1466, Secaucus, NJ 07094 • Clinic Tel: (201) 974-2026 – Fax: (201) 866-5805

STUDENT MEDICATION FORM

STUDENT INFORMATION:

Student Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____

Parent/Guardian Phone: _____home _____work _____cell

_____

MEDICAL PROVIDER INFORMATION:

Physician's Stamp

Licensed Medical Provider: _____

Address: _____

Phone: _____ Fax: _____

_____

MEDICATION INFORMATION TO BE COMPLETED BY PHYSICIAN:

DOCTOR'S REQUEST/INSTRUCTIONS FOR STUDENT Start Date:_____

SELF ADMINISTRATION OF MEDICATIONS FOR POTENTIALLY LIFE THREATENING ILLNESS

The Medication listed below is to be self administered by my patient _____
STUDENT'S NAME

I hereby certify that my patient has a life threatening illness and that my patient is capable of and have been instructed in the proper administration of the required medication.

MEDICATION: _____ DOSE/ ROUTE:_____

_____ _____ _____
Physican's Signature Print Physician's Name Date

ADMINISTRATION OF MEDICATION BY SCHOOL NURSE

The Medication listed below is to be administered to my patient _____
STUDENT'S NAME

Medication: _____ Dose & Route: _____

Diagnosis:_____ Treatment to be continued until: _____

Significant Side Effects :_____

_____ _____ _____
Parent/Guardian Signature Print Parent/Guardian Name Date

PARENT REQUEST AND RELEASE TO BE COMPLETED BY PARENT/GUARDIAN

I request my child_____ to receive/self administer the medication designated above. I have been informed by the school district, its agents, servants, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the Secaucus Board of Education, its agents, servants, and employees from any and all claims, and shall defend any lawsuit that may arise out of or in connection with the administration of medication by my child.

_____ _____ _____
Parent/Guardian Signature Print Parent/Guardian Name Date

All medications must be in the original container appropriately labeled by the pharmacy or medical provider.