

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.

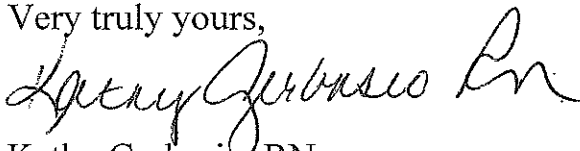
If you feel your child will need medication for headaches, cramps, allergy symptoms, etc., it will be necessary for you to obtain, from your child's physician, a Medication Form (enclosed). In addition, you must supply this medication for your child, which will be maintained in the Nurse's Office.

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:

Licensed Medical Provider: _____

Address: _____

Phone: _____ Fax: _____

Physician's Stamp

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: _____

Physician'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.