



Dear Parents and Guardians,

Over the course of the school year, we may have some students who require medication to be given during the school day. The school's policy for administering medication(s) during the school hours are as follows: **All medication needs require written orders/permission from your physician.** Policy guidelines are mandated from the state.

If a student requires non-prescription or "over the counter" medication, such as Tylenol, Motrin/Advil, allergy medication, cold/cough medication, etc., for the occasional or regular treatment of headaches, sore throats, cold, coughs, or allergies, the school requires written permission from the child's physician as well as from the parent. The attached is the form that may be used to grant written permission for medication the entire school year, or you may save it to use when your child has specific medication needs in school.

Please note: The school doesn't not keep a supply of medications for the students. Therefore, please send in your child's medication to the School Nurse. Medicines for your child, such as Tylenol, etc., may be kept in the Nurse's Office during the school year. These will be used for your child only and must be clearly labeled.

ALL medications must be brought to school in the original container. Medications should have labels with the student's name, the name of the medication, the dosage, the time(s) to be given, and the physician's name. (If you ask, most pharmacists will give you an extra labeled container for the medication kept at home.) No medication will be administered without proper authorization from the physician and parent.

Please fill out the attached medication permission form only if your child needs medication at school. If you have any questions, do not hesitate to contact me via email at mrenz@efsk-6.org.

Warm Regards,

Mary C. Renz, MSN, CSN, RN

Essex Fells School Nurse

mrenz@efsk-6.org , 973-226-0505 ext. 208

Essex Fells School

REQUEST FOR MEDICATION TO BE ADMINISTERED BY THE SCHOOL NURSE

PARENTAL REQUEST

Grade/Teacher _____

I, the parent of _____, request that the medication prescribed by my child's physician be administered to my child at the prescribed time.

I agree to bring a reasonable supply of the medication to the school nurse upon approval of my request. I (check one) do _____ do not _____ want my child to receive medication at 12:45 p.m. on early dismissal days.

Signature

Date

Address

Phone Number

PHYSICIAN'S STATEMENT

In order to protect the health of _____, it is necessary for her/him to have the following medication during school hours:

Medication _____

Dosage _____

Diagnosis/Reason for Medication _____

Time to be given _____

Duration to be given (example: September through June):

Date: From _____ To _____

Possible Side Effects:

I authorize the School Nurse to administer the above medication. In the absence of the School Nurse, I authorize the Superintendent to administer the above medication.

_____ YES

_____ NO

Doctor's Signature

Date