Dunellen Public Schools

Department of Special Services
Dunellen High School
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Dunellen, New Jersey 08812
Phone: (732) 400-5900

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DHS/LMS School Nurse

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Faber Nurse

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AUTHORIZATION FOR ADMINISTRATION OF
OVER THE COUNTER MEDICATION IN SCHOOL FOR ACUTE ILLNESSES

The following section is to be completed by the PARENT/GUARDIAN:

________________________________ __________________
Student's Name Grade

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

_______________________ __________________ __________
Parent/Guardian Signature Telephone Date

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY
AND MUST BE RENEWED ANNUALLY

The following section is to be completed by the PHYSICIAN:

Diagnosis: (check all that apply) Medication: (Select one)

_______Headache _______Ibuprofen _______mg. po q_______hrs prn

_______Toothache/Dental pain _______Acetaminophen________mg, po q ______hrs prn

_______Menstrual Cramps _______Other:______________mg q_____hrs prn

_______Musculoskeletal Pain

_______Earache

______ Fever

______ Other:___________________________

List significant side effects:____

Any restrictions or limitations:____

Date prescribed: _____________________________ Date to be discontinued: ______________

____
Physician's Name Address Telephone no.

____ _______________________

Physician's Signature Date

This form must be completed for **ALL OVER THE COUNTER MEDICATIONS**.
Ibuprofen, and acetaminophen will be provided by the school district.
Parent/Guardian will be notified prior to administration of the medication.