**JERSEY CITY PUBLIC SCHOOLS**
**OFFICE OF THE SCHOOL NURSE**

## PARENT/PHYSICIAN REQUEST FOR MEDICATION ADMINISTRATION

Date:______________________ School:_________________

### PARENT/GUARDIAN REQUEST:

Student:___________________ D.O.B.:___________________ Grade:______ Room: _______

I, parent/guardian of the above named child, request the medication prescribed by my Physician be administered to my child by the school nurse. I understand that I must bring In the medication in a container dispensed and properly labeled from a pharmacist or a Physician. The permission is granted for the current school year ONLY: __________________ and must be renewed each subsequent year. I understand that the medication will be destroyed if it is not picked within one week following the termination of the order, or one week beyond the close of school.

______________________________________ ______________________________________
Parent/Guardian Signature Address

______________________________________ ______________________________________
Date Phone

### PHYSICIAN' STATEMENT:

In order to protect the health of the above named child, it is necessary for him/her to have the following medication(s) during school hours.

| Diagnosis: |
|---|
| Medication: |
| Is this a controlled drug? Yes _____ No _____ DEA#: _______________________ |
| Dose: ________________________________________________________________________ |
| Time of Administration: __________________________________________________________ |
| Possible Side Effects: ____________________________________________________________ |
| Physicians Signature: ____________________________________ Date: _________________ |

**PHYSICAL EDUCATION PARTICIPATION:**

Is this child able to participate in competitive ***Physical Education***? Yes _____ No _____
If No, provide the reason:

____________________________________________________________

Does this child need to use the medication in order to participate in P.E. ? Yes _____ No _____
If YES, Medication, time dose, and amount to be administered:

__________________________________________________________________________________

__________________________________________________________________________________

Is this child able to participate in completive sports without restrictions? Yes _____ No _____
If No, provide the reason:

__________________________________________________________________________________

Does this child need to use the medication in order to participate in sports? Yes _____ No ____
If YES, Medication, time, dose and amount to be administered

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__________________________________________________________________________________

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**SELF ADMINISTRATION OF INHALANT DRUGS AND EPI-PENS ONLY:**

I, ____________________________ parent/guardian of the above named child give permission for him/her to self-administer _______________________________________________________.
Name of Medication

I acknowledge that the Jersey City Public Schools shall incur no liability as a result of any injury arising from self-administration of this medication. The permission is effective for the current school year and is to be renewed each subsequent year in the same matter.

**PHYSICIAN STATEMENT FOR SELF ADMINISTRATION OF INHALANT MEDICATIONS (MDI'S) AND AUTO INJECTORS (EPI-PENS)**

Do you feel this child can self-administer without supervision? Yes _____ No _____
The above named student has been instructed, directly observed, and has demonstrated the correct self-administration of this medication to me ____________________ Yes ____ No ____
Physicians Name

I authorize the school nurse to administer the named medications on page (1) of this statement.

| ____________________________________ | ____________________________________ |
|---|---|
| Physicians Signature | Physicians Address |
| ____________________________________ | ____________________________________ |
| Print Name | Telephone Number |
| ____________________________________ | |
| Date | |