INTERNATIONAL CHARTER SCHOOL OF TRENTON

105 Grand Street, Trenton, N.J. 08611 (609)394-3111 Fax (609)394-3116

Request for Administration of Medication

The State of New Jersey recommends and the Board of Trustees requires that if medication must be administered to a student during the school day, written permission must be given and signed by **both the parent and physician.**

For the safety of your son/daughter, medications are to be hand delivered to the school nurse by the parent/guardian in the original pharmacy labeled bottle/box. Medications are to be administered by the school nurse, unless otherwise directed by the physician.

Student: ______________________ Sex: M/F Grade ____ Age: __________

Diagnosis: ____

Name of Medication: ______________________ Daily or PRN __________

Dosage: __________________ Time of Administration: ______________

To begin on ______________ and conclude on ______________________

Possible side effects to be observed: ______________________________

Special instructions: ____

In the event of a field trip or reduced school day:

Can the dosage be omitted? Yes/No Can the dosage time be adjusted? Yes/No

Physician's signature: ______________________ **Date:** __________

Physician's name (print): ______________________ **Phone:** __________

I hereby release the Board of Trustees and its agents and employees from any liability concerning the administration of this medication.

Parent/Guardian signature: ______________________ **Date:** __________

Permission for Self –Administration of Medication

(Asthma and Epi-pen)

I hereby give permission for my child to self – administer his/her medication for **asthma or other potentially life-threatening illness**, if the school nurse is not physically present, or as directed by the physician. The student is capable of, and has been instructed in, the proper method of self-administration of the medication. **I hereby release the Board of Trustees and its agents and employees from any liability concerning the administration of this medication. MEDICATION SHOULD BE:**

__________ **in possession of student at all times**

__________ **stored in the school health office**

__________ **in possession of student on class trips**

Parent/Guardian signature: ______________________ **Date:** __________

Physician's signature: ______________________ **Date:** __________