

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

MR-01

MEDICATION REQUEST FORM

Pupil's Name: _____ School: _____ Grade: _____

Date of Birth: _____ Age: _____ ID#: _____

TO: The Parent/Guardian:

In order for your child to receive medication during school hours, please complete the parent/guardian section of this form and have your child's medical doctor complete the physician's section. Administration of medication in school should be avoided. Whenever possible, medication should be taken at home before and after school hours. Medication no longer required at school must be removed by the parent/guardian.

SECTION ONE (To be completed by parent/guardian)

PARENT AGREES TO/ REQUESTS THE FOLLOWING:

- I request that the school nurse administer medication to my child as prescribed.
- Medication will be brought to the school by parent or responsible adult.
- Medication will be provided in the original container, appropriately labeled by the pharmacy or physician.
- I will notify the school nurse promptly of any change in my child's medication.
- Medication must be picked up by an adult by the last day of school or when medication no longer needed.
- Yes No On a reduced school day medicate my child.

Signature of Parent/Guardian Date Telephone number

SECTION TWO (To be completed by physician/nurse practitioner per NJ law)

I certify that the above child is physically fit to attend school and is free of contagious disease.

I hereby request that the above named child be administered medication as prescribed by me as follows:

Name of Medication: _____ Form of medication: _____

Dosage: _____ Frequency: _____ Medication to be given: PRN Daily

Time Medication to be Administered at School: _____
(Actual medication administration time may vary by 1 Hour before or after time indicated above)

Special Instructions: _____

Diagnosis: _____

Purpose of Medication: _____

Side Effects: _____

Date to Begin: _____ Date to Conclude: _____
(Maximum one school year and/or to July)

Yes No This medication would be essential to the health of the child as ordered during the time of a class trip.

Physician's Name (Printed/Typed) Address

Physician's Signature Date Telephone Number
(Stamp not acceptable)

SECTION THREE (To be completed by staff)

Signature of School Nurse Date Received

Signature of Chief Medical Inspector Date