Dear Parents and Guardians

Please read our district's medication policies below as these are the guidelines we must ask you to follow when medications need to be administered in school. Please inform your child's school nurse directly of medical information regarding your child. Hospitalizations, surgical procedures, illnesses, injuries, immunization updates and medication changes are examples of information that needs to be reported to the school nurse either by phone, a note, or an email. Also, please be sure to notify the school nurse if your child is taking medication at home as the nurse would be the first line of defense for any adverse reactions to medications while your child is attending school.

Thank you for your cooperation in all areas that concern the health and well being of the students at Rockaway Borough Schools.

Rockaway Borough Schools Medication Policy

If medication is necessary during school hours, it will be administered by the school nurse only after the following conditions are met:

1. A written order from the physician to the school indicating the reason for the medication, time (or circumstances) to be given, starting and finishing dates, amount to be given and the physician's name. **This includes ALL over-the-counter non-prescription medications such as Tylenol, Advil, Tums, etc**. Please understand **no exceptions** can be made to this policy. Medication permission forms are available on the school website and from the school nurse.
2. **New Jersey law requires all students taking asthma medication in school to have an Asthma Action Plan, completed and signed by the student's physician and parent, on file.** Asthma Action Plan forms are available on the school website and from the school nurse.
3. Written permission from the parent, giving specific information.
4. Medication must be furnished by the parent **in the original pharmacy bottle**, with recent date and label with student's name, medication name, dosage, time to be given, and physician's name. **Over-the-counter/non-prescription medication must be in original container/original packaging.**
5. Medication will be accepted from and given to a parent or legal guardian only. No child is to carry medication of any kind, (unless approved by his or her physician to self-carry/self-administer his or her asthma inhaler or epi-pen). This includes cough drops, Tylenol, etc.
6. Cough drops require a parent note and must be kept in the nurse's office. Students are not permitted to keep cough drops or lozenges in their desks or in backpacks. Cough drops must be brought into school by a parent or other responsible adult.
7. If your child takes a bus to afterschool care please understand medications cannot be sent from school on the bus with your child, (this includes cough drops). If your child needs to take medication both in school and at his or her afterschool care center, please make arrangements to have a supply of medications both in school and at your child's afterschool care center.
8. If your child attends the BoroKids onsite before/after school program, and will need to take medications before or after school hours, (such as inhalers or epipens), please make sure to make arrangements with BoroKids regarding your child's medication needs as medications in the school health office are only accessible between 8:15am and 3:25pm, and only when a nurse is present.

Thomas Jefferson School
103 East Main Street
Rockaway, New Jersey 07866
Telephone: 973-625-8603
Fax: 973-625-7355

REQUEST FOR MEDICATION TO BE ADMINISTERED BY THE SCHOOL NURSE
2020-2021 SCHOOL YEAR

PARENTAL REQUEST:

I, _____, the parent/guardian of _____, hereby request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time below. I understand that students are not permitted to carry medications of any kind into school, and agree to bring the medication to school myself, or send it in with another adult. I agree to bring a monthly supply of the medication to the school upon the approval of my request.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Address Phone Number

PHYSICIAN'S STATEMENT:

In order to help _____, it is necessary for her/him to have the following medication during school hours.

MEDICATION:

DOSAGE:

TIME TO BE ADMINISTERED:

PURPOSE OF MEDICATION:

POSSIBLE SIDE EFFECTS:

DIAGNOSIS:

I hereby authorize the school nurse to administer the above medication.

_____ _____
Physician's signature Date

_____
Physician's Name

_____ _____
Address Phone Number

FOR SELF-ADMINISTRATION ONLY
PLEASE CHECK IF APPLIES:
_____ This child has been instructed in the safe use of this medication and is capable of carrying and self-administering this medication.

_____ _____
Physician's signature Date