Hopatcong Borough Schools

Mr. Art DiBenedetto
Superintendent of Schools

Learning Today. Leading Tomorrow.

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

To be completed by parent/guardian before any prescribed or over-the-counter medication, other than epinephrine or inhalers, may be administered in school.

Student _____ School Year _____

I request and consent to the administration of the following medication _____ to my child by the school nurse or, in her absence, another registered nurse. This student would not be able to attend school if the medication is not administered during school hours.

I understand that the nurse and physician will communicate with one another as needed in order to safely and effectively carry out these medical orders. I further understand that this releases the school personnel from liability should a reaction result from the medication.

I understand that I must bring the medication to the school nurse in the original, labeled container from the pharmacy and that I am responsible for replacing the medication when it expires or when otherwise necessary. I agree to pick up any unused medication at the end of the school year, when the medication becomes outdated, or when the medication is no longer necessary, whichever comes first. I understand if I do not pick up the medication, it will be discarded.

I further understand that this releases all school personnel from liability should a reaction result from the medication.

I acknowledge that I have been informed that permission for administration of the medication will be effective only for the school year as indicated above, and that a new parent authorization and physician order is required every school year.

Date:_____ Parent Signature:_____