HAMPTON PUBLIC SCHOOL

(908) 537-4101

AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION IN SCHOOL FOR ACUTE ILLNESSES/CONDITIONS

Our School Medical Director, Felix Foschetti, MD has authorized administration of the following medications by the School Nurse in the School Health Office. However, Parental/Guardian permission is required before a student can receive any of the listed medication. If you would like your child to be able to receive any of the listed medication in the school if needed, please complete the following and return it to the Main Office or Health Office. Students will receive only ONE DOSE during the school day. Telephone verbal permission from a parent/guardian will be requested prior to the administration of medication. Our goal as a community is to keep our children in school to promote academic achievement.

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT/GUARDIAN:

STUDENT'S NAME _____ **GRADE** _____

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C.:6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the School Nurse and others may require their presence at another location at the time the medication is needed. I understand the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I also agree to disclose any allergies to medication or other medications my child is taking to the School Nurse.

I authorize the administration of (Check all that apply)

____ Acetaminophen dosed according to weight and product label.

____Ibuprofen dosed according to weight and product label.

____TUMS dosed according to product label.

____ Cough Drops (one every two hours)

Signature (parent/guardian):_____ date:_____

Name:_____ work phone:_____

Home phone:_____ Cell:_____

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY.