

MOORESTOWN TOWNSHIP PUBLIC SCHOOLS
Administration Building, 803 North Stanwick Road
Moorestown, New Jersey 08057
(856)778-6600

Dear Parents/Guardians:

The following guidelines on the dispensing of medication in the schools have been approved by the Moorestown Board of Education:

- A. The parent or guardian must provide a written request for the administration of the prescribed medication at school (attached).
- B. Non-prescriptive drugs require the same guidelines listed below (including aspirin, cough syrup, cough drops, decongestants, herbal remedies, or vitamins).
- C. Written orders are to be provided to the school from the private physician, giving the name of the drug, dosage, and time of administration. (Some physicians will detail the diagnosis of illness involved and the side effects of the drug).
- D. The medication shall be in the original container appropriately labeled by the pharmacy or physician.
- E. The certified school nurse or parent/guardian are the only persons permitted to administer medication in the schools.
- F. All medication is to be brought to the nurse by parent/guardian!**

Forms are available in each nurse's office to meet these requirements. Your cooperation in this matter will be appreciated.

NOTE: Consideration for field trips:

Children who require any medication on a field trip will need special consideration when planning school trips. The following is a list of appropriate options. Of course, each of these would require approval of the child's parent(s)/guardian(s) and physicians.

- A. Withholding medication during the course of that particular activity, and giving it when the students returns.
- B. Requesting that a parent or guardian accompany the group and administer the medication to the child.
- C. If none of the above options are possible, please notify the school nurse.

MOORESTOWN TOWNSHIP PUBLIC SCHOOLS
MOORESTOWN, NEW JERSEY

TO: SCHOOL NURSE

FROM: DR. _____

TELEPHONE _____

ADDRESS _____

RE: STUDENT'S NAME _____

This student is under my medical care. His/her treatment requires dispensing medication as stated below.

Please allow this patient to adhere as closely to his/her medication schedule as possible. He/she must take the medication in the school health office.

DIAGNOSIS _____

MEDICATION _____

DOSAGE _____

ADMINISTRATION TIME(S) AT SCHOOL _____ NO. OF DAYS _____

PRECAUTIONS/SIDE EFFECTS

Date _____ Doctor/NP Signature _____

As parent or (legal guardian) of _____.

a student in the _____ School, I hereby request the school authorities to allow my child to take medication during school hours as prescribed by

Dr. _____.

I understand the medication will be brought to school with written prescription on the container. THANK YOU.

Signature of Parent/Guardian