KEARNY PUBLIC SCHOOLS
KEARNY, NJ
MEDICATION PERMISSION

Parental Request

I, _____ request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time. Also, in the case of an anaphylactic reaction the trained epi-pen designee may administer the prescribed epi-pen. I agree to bring a supply of the medication to the school nurse in its original container upon her request.

_____ _____
Parent's Signature Date

Physician's Statement

In order to protect the health of_____it is necessary for him/ her to have the following medication during school hours.

MEDICATION:

DOSE and ROUTE:

TIME:

SIDE EFFECTS:

PURPOSE:

DIAGNOSIS:

I authorize the school nurse to administer the above medication.

Asthma Inhalers:

Student may_____self administer **May not_____self administer**

Keep medication in nurse's office_____ **Keep medication with student_____**

(If child self administers and carries his inhaler he/she must notify nurse when medication is being used so it can be documented. (An additional inhaler should be kept in nurse's office as well).

Signature of physician/stamp_____ Date_____