



ACADEMY OF OUR LADY OF MOUNT CARMEL

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Dear Parents/ Guardians,

If it is necessary for your child to receive any medication during school hours, school health policy requires that you provide a written request for the administration of the prescribed medication. Your private physician must also provide written orders detailing the diagnosis or type of illness being treated, the name of the medication, dosage, administration route, time of administration and length of treatment. This includes any medications that a student will self-administer due to asthma or other potentially life-threatening illness. Herbal remedies, such as cough drops and nutritional supplements are not considered medications and are not to be administered in school. Medications should be in the original pharmacy labeled container, which will remain in school.

The school nurse or parent/guardian is the only one permitted to administer medication in the school and/or on school trips. In the event that the school nurse is not present, the parent can give written authorization for a delegate to administer the medication. The nurse will review in advance the administration procedure with the delegate.

The necessary form is enclosed for your convenience.

Sincerely,

Terri Silvestre RN
School Nurse

**AUTHORIZATION TO ADMINISTER MEDICATION OR PROCEDURE FOR
SIMPLE/COMPLEX INTERVENTION**

To be completed by PARENT/GUARDIAN

PART A I authorize the non-public school nurse/principal/administrator to contact my primary health care provider on any questions related to my child's care. I also authorize the non-public school nurse, or other unlicensed assistive personnel (UAP) educated by the nurse, to administer the above medication*/procedure to my child during regular school hours and at other times when my child is participating in a school related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication or procedure; that I will indemnify and hold harmless The Board of Education/School District, Bergen County Department of Health Services and their employees, school, school nurse and other school employees against any claims arising from the administration of medication to my child.

Signature _____ Date _____
Parent/Guardian

**Herbal remedies and nutritional supplements are not considered medications and are not to be administered in school.*

To be completed by PRESCRIBING HEALTH CARE PROVIDER

PART B

NAME OF CHILD: _____ GRADE: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

FREQUENCY & DIRECTIONS: _____

DESCRIPTION OF PROCEDURE: _____

PURPOSE OF DRUG/PROCEDURE: _____

POSSIBLE SIDE EFFECTS: _____

APPROPRIATE FOR DELEGATION TO UAP: (MUST BE CHECKED) YES NO

Signature: _____ Date: _____
Health Care Provider

Address: _____ Telephone: _____

To be completed by NONPUBLIC SCHOOL NURSE if necessary.

PART C

Orders reviewed during phone conversation with prescribing practitioner.

Signature: _____ Date: _____
Non-public School Nurse

This authorization is effective for the current school year only and must be renewed annually.

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

NAME OF STUDENT: _____ GRADE: _____

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

DIRECTIONS: _____

POSSIBLE SIDE EFFECTS: _____

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

Signature of Prescribing Physician

Date

Address

Phone

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurse and other school employees against any claims arising from the self-administration of medication by my child.

Signature of Parent/Guardian

Date

This permission is effective for the current school year only and must be renewed annually.