

SPRINGFIELD TOWNSHIP SCHOOL DISTRICT



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DR. BETH GODETT SUPERINTENDENT

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STUDENT MEDICATION PERMISSION FORM

In accordance with New Jersey State Law, Springfield Township Board of Education policy states that: *school nurses only are to administer any medication to students.* \* This is to be done *only* if medication has been prescribed by the child's physician who has noted diagnosis, medication, dosage and time. This includes any over-the-counter drug. In addition, parent/guardian must sign permission form below and return to the school nurse.

Prescription must be in properly labeled pharmacy containers: over-the-counter medications must be in the original container and accompanied by physician's note. Medication should be brought to school and picked up by designated adult. All medications sent to school will be locked in the nurse's office. *Students are not to carry any medication.*

\*State Law allows for pupils to self-administer medication for asthma or other potentially life-threatening illnesses provided certain stipulations are followed.

\*\*\*\*\*  
TO BE COMPLETED BY PHYSICIAN

Authorization is hereby given for medication to be administered in school to: \_\_\_\_\_

Name of Student \_\_\_\_\_ School \_\_\_\_\_ Grade/HR \_\_\_\_\_

Medication \_\_\_\_\_ Diagnosis \_\_\_\_\_

Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Time to be given \_\_\_\_\_

\*Self-administration of medication shall be limited to the use of inhalers or epipens. I hereby certify that this student has \_\_\_\_\_ (a potentially life-threatening condition); has been trained in the use of \_\_\_\_\_ (name of inhaler/epipen), and is capable of self-administration of this medication for the \_\_\_\_\_ school year.

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\*\*\*\*\*  
TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give permission for the school nurse to administer the above medication (which has been prescribed by my doctor) to my child \_\_\_\_\_. I shall bring the medication in its original container, properly labeled from the pharmacy. I release the Springfield Township Board of Education and its employees from any liability concerned in the administration of such medicine.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

\*I give my child permission to self-administer \_\_\_\_\_ (name of inhaler/epipen) in the absence of their parent/guardian or school nurse. I relieve the Springfield Township Board of Education and its employees of any liability, losses, damages incurred by the Springfield Township Board of Education due to self-administration of medication of my child.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_