

Clifton Public Schools  
Health Services

Dear Parents/Guardians;

We are writing to ask your cooperation with our efforts as we attempt to best serve the school-age child regarding the administration of medication during school hours. State law prohibits students from having medication in their possession and from administering their own medication. If the school nurse is to administer the medication, parental permission and a written statement from the physician prescribing the medication is required. This mandates applies to all herbal and non-prescription medications also.

**Parent's Request for Administration of Medicine at School**

I request that my child \_\_\_\_\_ receives  
(child's name)  
the medication prescribed by \_\_\_\_\_ for the  
(physician's name)  
period from \_\_\_\_\_ to \_\_\_\_\_. School \_\_\_\_\_ Date \_\_\_\_\_  
My child should take this medication on: 1. Field Trips Yes \_\_\_\_\_ No \_\_\_\_\_  
2. Early Dismissals Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian Signature)

**Physician's Request for Administration of Medication at School**

Name of Student \_\_\_\_\_ Date \_\_\_\_\_  
Name of Drug \_\_\_\_\_ Time of Administration \_\_\_\_\_  
Dosage \_\_\_\_\_ Reason for Medication \_\_\_\_\_  
Possible Side Effects \_\_\_\_\_  
Physician's Signature \_\_\_\_\_  
Physician's Name \_\_\_\_\_  
Physician's Address \_\_\_\_\_ Phone # \_\_\_\_\_

Please send medication to school in a pharmacy container labeled with child's name, drug name, dosage, specific time to be given and prescribing physician's name to assure the correct identification of the drug. Thank you for your cooperation in this matter.

**Date \_\_\_\_\_ Approved by School Physician \_\_\_\_\_**

08/05