

**CALIFON PUBLIC SCHOOL**  
**6 School Street**  
**Califon, NJ 07830**  
**Phone 908-832-2828      Fax 908-832-6719**

**School Medication Policy**

- No medication can be administered to a student without the written authorization from the parent and physician.
- Written authorization is required for all medications including over-the-counter medications such as Tylenol, Advil, cough medicine, cough drops and medicated skin creams.
- A medication authorization form must be completed by the physician and signed by both the physician and parent.
- If your child needs to receive more than one medication, please feel free to make copies of the form or call the office for additional copies.
- Medication that is brought into school **MUST BE TRANSPORTED BY AN ADULT AND IN ITS ORIGINAL CONTAINER.**
- If you are bringing in a prescription medication, ask the pharmacist to give you two labeled bottles when you drop off the prescription. With prescription medications, please bring in to school only the amount of medication that will be administered in school so that the medication does not have to travel back and forth from school every day.
- The only medications that students are allowed to carry with them and self-administer are those medications needed for potentially life-threatening illnesses such as inhalers for asthma or epipens for anaphylaxis. The students may carry these medications only when the student is able to demonstrate proper self-administration technique. Self-administration forms need to be signed by the physician and parent then returned to the Health Office.
- All other medications will be kept locked in the Health Office and will be administered to the student at the time designated by the physician.
- The certified school nurse, parent or guardian are the only ones permitted to administer medication to students in school or on class trips.

If you have any questions concerning the school's medication policy, please do not hesitate to call me. The safe handling of medication is an important lesson to our children.

Linda Patterson, RN  
School Nurse

(please see other side)

**CALIFON SCHOOL MEDICATION AUTHORIZATION**  
**SCHOOL YEAR \_\_\_\_\_**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medication: \_\_\_\_\_

Dose to be administered: \_\_\_\_\_

Time to be administered: \_\_\_\_\_

Number of days to be administered **or** entire School Year \_\_\_\_\_:  
\_\_\_\_\_

Reason for medication: \_\_\_\_\_

Side effects: \_\_\_\_\_

**Medication order for class trip days (most trips are full day 9:00 – 3:00)**

\_\_\_\_ Dose may be omitted                      \_\_\_\_ Dose to be given upon return to school

\_\_\_\_ Other (please specify change): \_\_\_\_\_

**Medication order for early dismissal days (1:10 PM dismissal)**

\_\_\_\_ Omit afternoon dose

\_\_\_\_ Maintain original order

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name, address, and phone number of physician (printed/stamped):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent Authorization:**

I hereby give permission for my child to receive medication at school as prescribed by my child's physician. I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and medications.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_