FAIRFIELD PUBLIC SCHOOLS
FAIRFIELD, NEW JERSEY 07004

MEDICATION PERMISSION FORM

1. Students requiring medication (prescription or over-the-counter medications) during school hours, must have written authorization from their private healthcare provider. Orders must be documented and requested on the prescribing physician's letterhead clearly displaying the physician's address and phone number. The physician MUST sign and date the letter. Included in the letter, the following needs to be identified: student's name, date of birth, diagnosis, name of medication, dosage, time, frequency and duration of administration, and possible side effects.
2. The parent/guardian must hand deliver this completed and signed permission form to school along with the medication in it's original container to the school nurse. The medication must be appropriately labeled by the pharmacy with the name of the prescribing physician, student's name, name of medication, dosage, and time of administration.
3. Parent/guardian is responsible for retrieving medication requested by the parent or school nurse. If not retrieved by the last day school is in session, medication will be discarded.
4. The school district follows the District Policy 5330-Administration of Medication, when medication is to be administered.

Please note: Controlled medications are administered on school premises and excludes class trips. **Non-controlled medication can be administered as prescribed during class trips.**

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Student's Name_____ D.O.B._____

School_____ Grade/Teacher_____

Name of Medication_____

Diagnosis_____

Dosage_____ Time/Frequency/Duration_____

Possible Side Effects?_____

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_____

Prescribing Physician's Printed Name

_____ _____

Prescribing Physician's Signature Date

_____

Prescribing Physician's Address

_____ _____

Telephone Number Fax Number

_____

Parent/Guardian Printed Name

_____ _____

Parent/Guardian Signature Date

Controlled Medication

Principal's Signature:_____ Date:_____