PERTH AMBOY PUBLIC SCHOOLS

Mrs. Eva Kucaba – Supervisor of Nursing and Health Related Services
(732) 376-6200, Ext. 30-445

ADMINISTRATION OF MEDICATION IN SCHOOL

Dear Parent/Guardian:

Administrative policy of the Perth Amboy Public Schools requires the school nurse to have written permission from you and the attending physician. Medication administered by the school nurses should only be done in exceptional circumstances wherein the child's health may be jeopardized without it.

****

Parent's Section:

As the parent/guardian of_____, Grade_____, Homeroom _____

Home telephone:_____, Work Number:_____, Cell Number:_____

I request that the below medication, as prescribed, be administered to my child.

_____ _____
Parent's Signature Date

Please have your doctor fill in the information requested on the form below. This form must be returned to the school nurse with a supply of the medication in the original, appropriately labeled pharmacy container by the parent/guardian.

****

Physician's Section:

Diagnosis for which medication is given:_____

Medication:_____ Dosage:_____

Times/Repetitions:_____ Contraindications:_____

Side Effects:_____

Other Information:_____

Physician's Name:_____ Date:_____

Physician's Signature:_____ Telephone number:_____

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Side Effects:_____

Other Information:_____

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Physician's Signature:_____ Telephone number:_____

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ADMINISTRCION DE MEDICINAS EN LA ESCUELA

Estimado Padre/Madre/Guardian:

Las normas administratvas de las Escuelas Públicas de Perth Amboy requieren que la enfermera escolar tenga permiso de usted y del medico de su niña/niño. La enfermera debe administrar medicina solo en casos excepcionales, en cuales la salud del niño pueda estar en peligro.

****

Seccion para llenar los padres:

Como madre/padres de:_____, del grado_____, salon de hogar_____,
Apellido Primer Nombre

de teléfono_____, de tel. en su trabajo:_____, **Cell phone:**_____,

Yo pido que se le administer a mi hija/hijo la medicina indicada debajo, según recete el doctor.

_____ _____
Firma del Padre/Madre Fecha

Por favor pidale a su doctor que procvea la información deceada debajo. Este formulario se le debe devolver a la enfermera de la excuela junto con la medicina en su botella **original con la etqueata de la farmacia.**

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Sección para llenar el Doctor:

Diagnósis que require esta medicina:_____

Medicina:_____ Dósis:_____

Veces al dia:_____ Contraindicaciones:_____

Efectos que pueda tener:_____

Otra información:_____

Nombre del doctor/la doctora:_____ Fecha:_____

Firma del doctor/doctora:_____ # de tel._____

PERTH AMBOY PUBLIC SCHOOLS

Mrs. Eva Kucaba – Supervisor of Nursing and Health Related Services

(732) 376-6200, Ext. 30-145

Physician's Medical Report

Student/Grade/Homeroom:_____ **Date:**_____

Dear Doctor

The person named above is a student at _____ **and has been treated by/ sent to you for following conditions:**_____

_____

_____

Please Supply the following information for my records:

1. **Diagnosis:**_____
2. **Restrictions/Precautions, if any:**_____

   _____
3. **Date student can return to school (if applicable)** _____
4. **Medication required during school Hours?** _____**Yes** _____ **No**
   If yes, please supply name of medication, dosage, and how often to be given:

Any additional pertinent information: _____

_____

Please sign here and return to me.

Physician's Signature: _____ **Date:** _____

Thank You for your prompt attention.

Regards,

Perth Amboy Education Center
Nurse's Office
178 Barracks Street
Perth Amboy, NJ 08861
(732)376-6200 ext. 31415