

Roxbury Township Public Schools Succasunna, NJ

Medication Policy

Effective October 2013, Roxbury Township Board of Education adopted revised policy #5330 regarding the administration of medication to students. According to the policy, "medication" means any prescribed or over-the-counter medicine. This includes such medications as Tylenol, aspirin or cough drops.

The following guidelines **must** be followed when the administration of medication in school is necessary:

1. The parent or guardian **and** private physician must provide a written request for the administration of the prescribed medication at school. The physician's written order must include the following:
 - a. Name of the student
 - b. Diagnosis or type of illness involved
 - c. Name of the medication
 - d. Dosage
 - e. Time of administration
 - f. Time when its use will be discontinued
 - g. Side effects
2. Currently dated **medication must be brought to the Health Office by the parent/guardian in the original labeled container.** Most pharmacies will provide you with an extra bottle properly labeled for school.
3. Medication no longer required must be promptly removed by the parent/guardian.
4. Medication will only be administered to students in school by the school physician, a certified or non-certified school nurse, a substitute school nurse employed by the district or the student's parent/guardian. Students with asthma or other potentially life threatening illnesses will be allowed to self-administer medication when a nurse is not physically present at the scene. Permission for such administration must be on file in the office of the school nurse and comply with the conditions for granting permission.

Medication permission slips may be obtained from your school nurse or on-line at roxbury.org

Thank you for your attention to this matter.

Roxbury School District Medication Administration Daily Log (to be completed for each medication)

School Year _____

Name of Student _____ Date of Birth _____ Sex ____ Grade/ Teacher) _____

**Parent signature granting permission for administration of medication/sharing of information with appropriate staff members:*

Date _____

Name and Dosage of Medication _____ Route _____ Time(s) Given in School _____.

Start date _____ End date _____ (Medication must be in the original container as dispensed by the pharmacy or physician)

Reason for medication _____

**Physician signature* _____ *Date* _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
June																															

INITIAL SIGNATURE
(of person administering medication)

CODES*

1. _____
2. _____
3. _____
4. _____

- _____ (A) Absent (O) No Show
- _____ (E) Early Dismissal (W) Dosage Withheld
- _____ (F) Field Trip (X) No School (e.g., holiday, weekend, snow day, etc.)
- _____ (N) No Medication Available

***See reverse side for reporting significant information.**

