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# CENTER FOR LIFELONG LEARNING

EDUCATIONAL SERVICES COMMISSION OF NEW JERSEY

## 333 Cheesequake Road, Parlin, New Jersey 08859 (732) 727-3736 Fax (732) 727-3756

**Mary Beth Conley Michael Kane Antoinette Nicholasi**

**Principal Vice Principal Vice Principal**

**Authorization to Administer Medication**

**2023-2024**

Dear Parent/Guardian and Physician:

In order to meet the state requirements, the following form must be completed in order for your child to receive medication while in school by the school nurse. The health office will provide lock boxes to transport any and all medications. At no time will students be permitted to carry or administer their own medication. The medication must be in the original container and have the current prescription label detailing the correct name, dosage and frequency. The lock box will be sent home with a letter stapled securely to the handle. If there are any questions, please call the health office at 732-727-3736, extension 7741 or 7742.

I give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be administered the following medication(s) ordered by my child’s physician while in school.

Date:\_\_\_\_\_\_\_\_\_\_\_ **Signature of parent /guardian**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medication Dosage Time of administration Purpose

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medication Dosage Time of administration Purpose

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medication Dosage Time of administration Purpose

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medication Dosage Time of administration Purpose

 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medication Dosage Time of administration Purpose

**Physician’s Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Stamp**

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**Principal Vice Principal Vice Principal**

**Autorización para administrar medicamentos**

**2023-2024**

Estimado padre/tutor y médico:

Para cumplir con los requisitos estatales, se debe completar el siguiente formulario para que su hijo reciba medicamentos mientras está en la escuela por parte de la enfermera de la escuela. La oficina de salud proporcionará cajas de seguridad para transportar todos y cada uno de los medicamentos. En ningún momento se permitirá a los estudiantes llevar o administrar su propio medicamento. El medicamento debe estar en el envase original y tener la etiqueta de prescripción actual que detalla el nombre, la dosis y la frecuencia correctos. La caja de seguridad se enviará a casa con una carta grapada de forma segura a la manija. Si hay alguna pregunta, por favor llame a la oficina de salud al 732-727-3736, extensión 7741 o 7742.

Doy permiso para que a mi hijo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ se le administren los siguientes medicamentos ordenados por el médico de mi hijo mientras está en la escuela.

Fecha:\_\_\_\_\_\_\_\_\_\_\_ **Firma del padre /tutor**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosis de medicamentos Tiempo de administración Propósito

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosis de medicamentos Tiempo de administración Propósito

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosis de medicamentos Tiempo de administración Propósito

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosis de medicamentos Tiempo de administración Propósito

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosis de medicamentos Tiempo de administración Propósito