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 containe**r. 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 www.roxbury.org/Page/3875.

Thank you for your attention to this matter.

ROXBURY SCHOOL DISTRICT | Medication Administration Daily Log (to be completed for each medication)

School Year *20 _____ / 20 _____*

v.20190127

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

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

Name of Parent _____ Signature _____ Date _____

Name & 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 _____ ***PLEASE STAMP REVERSE SIDE >>>

	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
Sep																															
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Dec																															
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Mar																															
Apr																															
May																															
Jun																															

Initial & Signature of Person administering medication — Codes^

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

(A) Absent
(O) No Show
(W) Dosage Withheld
(N) No Medication Available
(E) Early Dismissal
(F) Field Trip
(X) No School (e.g. Holiday; Weekend; Snow Day; etc.)

^See reverse side for reporting significant information.

Date	Explanation (with Signature)	Date	Explanation (with Signature)