Yeshiva Ktana of Passaic / BYP Office of the School Nurse

MEDICATION ADMINISTRATION IN SCHOOL PERMISSION FORM 2023-2024

For Prescription and Student Specific Over-the-Counter Medication that must be given in school

THIS FORM IS VALID ONLY IF SIGNED BY LICENSED MD AND COSIGNED BY PARENT YEARLY

PRESCRIPTION MEDICATION MUST BE IN A CORRECTLY LABELED CONTAINER FROM THE PHARMACY

Physician Please Note: This form is for one child only.

Remember - when possible, medication should be scheduled at times other than school hours.

Name of Student_____ Date of Birth: _____Grade:_____

Diagnosis for which medication is prescribed: _____

Duration: □ This is a LONG TERM MEDICATION* □ This is a SHORT TERM MEDICATION

Other medical conditions: _____

Name of Medication: _____

Circle one: Tablet/capsule Liquid Inhaler Nebulizer Injection Other: _____

Route of Administration: _____ Dosage: _____ Time(s) of Administration (in school): _____

Specific directions /side effects or any other information for administration: _____

***Please note: Long term orders are for school year only and all orders are discontinued on 06-30-24**

Other medication(s) being taken at home by student:

Medication Taken/Dose/Time:	For:	□ At Home □ At School
Medication Taken/Dose/Time:	For:	□ At Home □ At School
Medication Taken/Dose/Time:	For :	□ At Home □ At School
Medication Taken/Dose/Time:	For :	□ At Home □ At School
Please use other side of paper if additional space for listing medications is needed		

STUDENTS REQUIRING MEDICATIONS DURING THE SCHOOL DAY (HERBAL, OVER THE COUNTER, OR PRESCRIPTION) MUST HAVE THE MEDICATION ADMINISTRATION FORM FILLED OUT AND SIGNED BY THE MD and UPDATED YEARLY OR WHENEVER THERE IS A MEDICATION CHANGE.

Name of Licensed Prescriber: _____ Emergency Phone: _____

Date: _____ Licensed Prescriber Signature: _____ **(MANDATORY)**

I hereby request and authorize the school nurse or her designee to administer the above medication(s) to my child and I release the school personnel from liability should adverse reactions occur from administration of the medication

Parent/Guardian's Name (print) _____Parent/Guardian's Contact # _____

Date: _____ Parent/Guardian's Signature: _____ **(MANDATORY)**

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