

Cape May County Technical School District  
188 Crest Haven Road  
Cape May Court House, New Jersey 08210  
(609) 465-2161  
Fax: (609) 465-5033  
e-mail:lzipparo@capemaytech.com

## **MEDICATION POLICY**

Dear Parent/ Guardian,

The goal of the Cape May County School Health Services is to promote health and wellness. In accordance with this goal, school policy allows for the administration of medication by the school nurse “during school hours when failure to take such medication would jeopardize the health of the student, or, the student would be unable to attend school if the medication were not available to him/her during school hours”. School policy mandates that before any medication be administered during school hours, the written request of the parent/guardian and the physician, which shall give permission for such administration, be obtained and releases the school board and their employees from liability for administration of medication.

If your child needs medication to be administered during school hours, please have the prescribing physician complete the top part of the attached form. You will need to complete the bottom part of the form.

**Please note: Both portions of the attached form must be completed and signed by the physician and parent/guardian before any medication is administered by the school nurse. All medication must be in the original container. All controlled medication needs to be brought in by the parent (examples: Ritalin, Adderral), but if you are unable to do so, please call the school nurse.**

If you have any questions regarding this policy, feel free to call me at: 465-2161 ext. 658.

Thank you,  
Lynda Zipparo, School Nurse

**SEE OTHER SIDE FOR MEDICATION AND TREATMENT ORDERS FORM**

Cape May County Technical School District  
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(609) 465-2161 ext. 658  
Fax (609) 465-5033

**MEDICATION AND TREATMENT ORDERS**  
(TO BE GIVEN BY SCHOOL NURSE)

No medication, will be administered without the written order from the student's physician and parent.

**PHYSICIAN PLEASE NOTE:**  
**Do not leave any blank spaces.** This form will be returned to you and cause a delay in your patient's medication or

Student Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Grade \_\_\_\_\_ FT ST

Diagnosis: \_\_\_\_\_ Any other diagnosis nurse should be aware of: \_\_\_\_\_

Name of medication/treatment to be administered: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s) to be given at school: \_\_\_\_\_ Total dose(s) per day: \_\_\_\_\_

If PRN provide criteria: \_\_\_\_\_

Duration of time may be administered: Start School Year: 20\_\_ to 20\_\_ **OR** Start date: \_\_\_/\_\_\_/\_\_\_ Stop Date: \_\_\_/\_\_\_/\_\_\_

Precautions/side effects, noting student's vocational shop limitations, if any (ie. No use of hazardous machinery, no heights or climbing ladders, no waterway activities-risk of drowning):

\_\_\_\_\_

Physician's name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Printed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: \_\_\_\_\_

\*\*\*\*\*

**Parent/Guardian completes this section:**

I give permission for the school nurse at Cape May County Technical School District to administer the above medication, as prescribed by my child's physician, to my child, \_\_\_\_\_. I understand that no medication will be given to my child unless it is brought to school in the original container, properly labeled, from the pharmacy/manufacturer. I release the school board, and its employees, from liability for administration of the above medication.

Parent/Guardian Name **Print:** \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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**In accordance with N.J.S.A. 18A:40 - 12.3 et. seq., Self-Administration of Emergency Medication, I certify**

that: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_  
Name of student - Please Print

is under my care for asthma/or, \_\_\_\_\_, a life threatening illness. He/She is capable of  
and has been instructed in the proper method of self administration of the prescribed medication for this illness.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Physician's Name - Please Print Physician's Signature Date

\_\_\_\_\_  
Street Address City/Town, State Zip Code Telephone

\_\_\_\_\_  
Name of Medication(s)

\_\_\_\_\_  
Dose Route Frequency **9** May administer inhaler \_\_\_\_ minutes prior to exercise

**Health Care Provider**, please review with your patient the following responsibilities: Do not share medication, including inhalers or epinephrine (ie. Epi-Pen) with others. Medications need to be labeled in the original container with name of medication, dose and student name. Only the dose of medication that needs to be taken during the school day should be carried by the student. Students needing to self-administer an inhaler or epinephrine must have the medication in their possession when off campus, including school/field trips, and at all sport practices and events.

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**Guardian completes this section.**  
My child has my permission to self-administer the above named medication as directed by the physician. I understand that the Cape May County Technical School District shall incur no liability or claims against the district or its employees as a result of injury arising from my child's use of the self-administered medication.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Guardian's Name - Please Print Signature Date

Phone in event of an emergency: **Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Other Emergency contacts:**  
Person Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_ Phone(s): \_\_\_\_\_  
Person Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_ Phone(s): \_\_\_\_\_

**SEE OTHER SIDE FOR ASTHMA PEAK FLOW ORDERS**

Cape May County Technical School  
188 Crest Haven Road  
CMCH, New Jersey 08210  
Health Office 465 - 1261 ext. 658  
Fax: 465:5033  
e-mail:lzipparo@capemaytech.com

ASTHMA  
PEAK FLOW IF ORDERED

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_

Student's peak flow optimal reading: \_\_\_\_\_

Notify physician if peak flow is: \_\_\_\_\_

and/or if pulse rate is: \_\_\_\_\_

Other instructions: \_\_\_\_\_

**SEE OTHER SIDE FOR SELF-ADMINISTERING OF EMERGENCY MEDICATION ORDERS**