



**Stanhope Public School District**

HEALTH OFFICE  
24 Valley Road  
Stanhope, NJ 07874

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www.stanhopeschools.org

**Alicia Finklea-DiCataldo**  
Principal

**Steven T. Hagemann**  
Superintendent

**Debi LeBrun**  
Business Administrator/Board Secretary

**School Administration of Medication Form**

**NJ State Law** requires that students receiving medication at school provide the following:

- 1.) Written consent of the parent/guardian **AND** physician for **prescription** as well as **over the counter (OTC)** medications.
- 2.) **ALL** medication **MUST** be labeled, and in the **ORIGINAL** container.
- 3.) Medication **MUST** be delivered to the school by the parent or guardian, or in a locked bag provided by the nurse.

**To be completed by Physician**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Condition requiring medication: \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_ Side effects: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

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**To be completed by Parent/Guardian**

I request that the school nurse administer \_\_\_\_\_ to my child  
**(Name of Medication)**

\_\_\_\_\_. I relieve the Board of Education and it's employees of liability for administration of this  
**(Name of Child)**

medication.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

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**Administration Approval**

\_\_\_\_\_  
Date of Administration Approval

\_\_\_\_\_  
Administration Signature

\_\_\_\_\_  
REV 9/2021