ARROWACADEMY
MARKED WITH PURPOSE
Health Office
90 Whippany Rd, Whippany, NJ, 07981
(973) 888-2083

MEDICATION PROTOCOL

Medication will be administered at school only when it is necessary for a student's health and continued attendance, and it must be done in accordance with the medication policy. **No student is to carry medication to and from school**. If it is necessary that medication be taken during school hours, the following is required:

1. All medication, prescription and over the counter, must be accompanied by a written request from a physician. These orders must include the reason for the medication, name of medication, dosage, time of administration, length of time for which it is required, and side effects of medication. Written orders must be renewed on an annual basis at the beginning of each school year.

2. All medication forms must be completed by the primary care provider and signed by parent/guardian for any medication to be administered to a student. No medication may be given until forms are completed.

3. Medication is to be in the correct prescription bottle, labeled with the name of the child, current dosage, date of prescription, and name of prescribing primary care provider.

4. Parents must bring all medications to the Health Office. Students should never carry medication to and from school.

5. Self-administration of medication for asthma or other potentially life-threatening illnesses require additional doctor and parent signatures.

6. Non Prescription medications (i.e. Ibuprofen, Tylenol) may only be administered when a Mandatory Medication Form is completed by the primary care provider and signed by a parent. These medications must come in the original container.

7. According to NJ Law, school nurses cannot administer alternative remedies such as herbal medications and essential oils.

8. No parent's or primary care provider's phone instructions can be accepted.

9. **Parents must pick up the medication from the nurse in June on the last day of school.** No medications will be sent home with a student. Medications will be properly disposed of if parents do not pick up the medication on the last day of school.

2024-2025 MANDATORY MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

NOTE: THE FIRST DOSE OF ANY MEDICATION MAY *NOT* BE GIVEN AT SCHOOL.

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ (DATE) TO _____ (DATE)

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

_____ PARENT SIGNATURE/DATE

_____ TELEPHONE NUMBER

_____ PHYSICIAN SIGNATURE/DATE

_____ TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

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_____ _____
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER

Health Office
90 Whippany Road
43 South Jefferson Road
Whippany, NJ
(973) 888-2083

Medication Permission Form

School Year_____

Student's Name: _____ DOB: _____

Name of Medication: _____

Dosage:_____ Route Given:_____

Time To Be Given:_____

Reason For Medication:_____

Medication To Be Given From _____ To_____
DATE DATE

Physician's Name:_____ Phone: _____

Additional Comments: _____

_____

I,_____, give permission for The Arrow Academy Staff to administer the above medication to my child, _____.

*Parent/Guardian Name (Print): _____

*Parent/Guardian Signature:_____ Date:_____

** Valid prescription must accompany this form

Revised 5/24

PERMISSION TO SHARE INFORMATION
2024-2025

As you are aware, everyday each of our students has contact with a variety of staff members; teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include; known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

Child's Name: _____

_____ **Yes**, I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ **No**, I do not give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ _____

Parent/Guardian Signature Date