Chancellor Academy
157 West Parkway • P.O. Box 338 • Pompton Plains • New Jersey 07444
Telephone: (973) 835-4989 • Fax: (973) 835-0768 • jfowler@chancelloracademy.net
Kevin McNaught / Executive Director • Christopher Pagano / Director

Dear Parent(s)/Guardian(s):

As per New Jersey State Law, in order for schools to administer:

1. A ***prescribed medication*** for a student, there must be a written physician's prescription on file along with a parent(s)/guardian(s) consent ,

   and

2. ***Over the counter medications*** such as Tylenol, Tums, etc. there must be a physician's written signed order on file along with a parent(s)/guardian(s) consent.

Therefore, I have attached a form for both prescription medications and over the counter medicine to be completed as soon as possible in order for your child to be administered any medication at school.

The top portion of this form must be completed by the parent(s)/guardian(s). The bottom portion is to be completed by your physician, or a copy of the written physician's prescription and/or may be submitted.

If there are any changes in your child's medication, you must update us with a new written doctor's prescription indicating the change.

If you have any questions or concerns, please contact Stacey Connolly, R.N. at 973-835-4989.

Sincerely,
Chancellor Academy

Christopher Pagano

Christopher Pagano
Director

Stacey Connolly

Stacey Connolly
B.S.N., R.N., C.S.N. - N.J.

/jf

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Medication Administration Permission Form Parent/Guardian Section

I grant permission for the school nurse at Chancellor Academy to administer prescribed medication to my child at the designated times during the school day (8:00 am to 2:00 pm).

Name: _____

Parent/Guardian Signature: _____ Date: _____

All medication must be properly labeled prescription container.

All medication including over the counter medications must have a prescription.

Medication Administration Permission for Physician Section

Name of Child: _____

Diagnosis: _____

Medication: _____

Dose & Frequency: _____

Mode of Administration: _____

Duration: _____

Medication: _____

Dose & Frequency: _____

Mode of Administration: _____

Duration: _____

Medication ***is / is not*** (circle one) required on field trips

Medication times ***may / may not*** (circle one) be adjusted to accommodate field trips

Physician's Signature: _____

Date: _____

Business Office
7 Industrial Road • Unit 203-A • Pequannock, New Jersey 07444

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