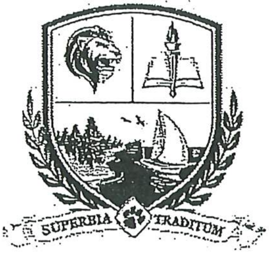

LACEY TOWNSHIP SCHOOL DISTRICT
OFFICE OF SPECIAL SERVICES

A Tradition Of Pride · A Tradition Of Excellence

JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Student Medical Concerns Form

Student's Name: ____ School Year:_______________

Date of Birth: _______________________ Grade: __________________School ____________________

Physician's Information

Name: ____

Address: ____

____

Phone: ____

My child has the following medical concerns that I wish to make the school nurse aware of (medical condition/diagnosis/treatment):

____

____

____

____

If your child requires medication to be administered during school hours:

1. Complete the appropriate **Medical Authorization Form** listed on the School District website.
2. Provide medication in its **original container.**
3. Prescription medications **must have pharmacy label**.
4. A parent/guardian must bring medication to the nurse's office. Students are **NOT** permitted to carry medication as per school policy.
5. For students that are permitted by their physician to self-administer their medication, please complete the **Medication Self-Administration Form**.

I understand that this information will only be shared with appropriate staff members on a need to know basis. Parent gives permission for the school nurse to communicate directly with child's physician.

____
Parent/Guardian Signature Date

Return this form directly to the school nurse at your child's school.

73 Haines Street · Lanoka Harbor, NJ 08734 · Phone: (609) 971-5850 · Fax: 609-971-2846