BELLEVILLE PUBLIC SCHOOLS
SCHOOL NUMBER TEN
527 BELLEVILLE AVENUE
BELLEVILLE, NEW JERSEY 07109
Web Site: www.bellevilleschools.org.

Joseph R. Rotonda
Principal

Main Office (973)450-3500 ext. 3101/3102
Fax: (973)751-9489
E-Mail: joseph.rotonda@belleville.k12.nj.us

April 11, 2017

Dear Parent/Guardian,

If your child suffers from allergies, please see your doctor now. Due to the already high pollen counts, many children are or will become uncomfortable while in school.

The students will be going outside for gym and recess during allergy season. If your child needs to stay indoors due to severe allergies, a medical note from your child's doctor is required. If eye drops and/or allergy medications are needed in school, a doctor's note is required and an adult must drop off the medication (see attached form).

If you have any questions or concerns, please contact me at (973) 450-3500 x3103.

Thank you,

Nicole Rusignuolo, RN

Ms. Nicole Rusignuolo, RN
School Nurse

BELLEVILLE PUBLIC SCHOOLS
Office of the Superintendent
102 Passaic Avenue
Belleville, New Jersey 07109
www.bellevilleschools.org

Richard D. Tomko, Ph.D.
Superintendent of Schools

Barbara Correnti
Director of Student Personnel Services
973-450-3500 X-1043
barbara.correnti@belleville.k12.nj.us

MEDICATION ADMINISTRATION IN SCHOOL - Request

To the Parent/Guardian of: ______________________________ Grade: __________

Students who need medication during school hours must:
- Present a written consent signed by the parent or legal guardian
- Present written orders from the MD including:
  1. dose, time and length of administration
  2. diagnosis/purpose for medication
- Bring the medication in the original bottle, properly labeled by a registered pharmacist*

***Elementary Level – Medication must be brought in by parent/guardian**

TO BE COMPLETED BY THE PHYSICIAN

Name of Student: ______________________________

Medication: ______________________________ Dose: ______________

Time to be given at school: ________________ Length of time: ________________

Diagnosis/Purpose: ______________________________

List of possible side effects (recommended): ______________________________

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Signature of Physician: ______________________________ Date: ______________

Name of Physician (print): ______________________________ Phone: ______________

TO BE COMPLETED BY THE PARENT/GUARDIAN

I give permission for my child ______________________________ to receive the above medication as directed.

Signature of Parent/Guardian: ______________________ Date: ______________
Telephone: Home ______________________ Work ______________

(Please check one) [ ] Administer on early dismissal days
[ ] DO NOT administer on early dismissal days

MUST BE RENEWED ANNUALLY

10/15