STUDENT AUTHORIZATION FOR SELF-ADMINISTRATION OF DAILY AND AS NEEDED ASTHMA PRESCRIPTION MEDICATION

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

N.J.S.A. Title 18A:40-12.3 directs that students may be permitted to self-administer medications for asthma or other potentially life-threatening illnesses provided proper procedures are followed.

The following section is to be completed by the PARENT/GUARDIAN:

_____ _____
Student's Name **Grade**

I request that my child be ALLOWED to carry the following medication _____ for self-administration. In school, pursuant to N.J.A.C 6A:16-2.3, I give permission for my child to self-administer medication, as prescribed on this form, for the current school year as I consider him/her to be responsible and capable of transporting, storing, and self-administration of the medication. I understand that the school district, its agents, and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the school district, its agents, and its employees against any claims arising out of self-administration or lack of administration of this medication by the student.

_____ _____ _____
Parent/Guardian Signature Telephone Date

The following section is to be completed by the Medical Provider:

Name of medication: _____

Dosage: _____ Route: _____Frequency: _____

If this is a daily administered medication, when should it be given? _____

If medicine is to be given "PRN," describe the indications: _____

How soon can the "PRN" medicine be repeated? _____

List significant side effects: _____

Any restrictions or limitations: _____

I verify that the child above requires this medication and

a. This student has been instructed in and is capable of the proper method of self-administration of the medication prescribed above.
b. This student understands the purpose, appropriate method, and frequency of use of the medication prescribed above.
c. The student's medication, if ingested by someone other than the student, will not cause severe illness or death.

_____
Physician's Name Address Telephone No.

_____
Physician's Signature Date

Approved by School Nurse:

_____
Signature Date

Approved by School M.D.:

_____
Signature Date

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