SELF ADMINISTRATION OF LIFE THREATENING MEDICATIONS

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. This form must be individually completed for **all prescribed medications**.

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, 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 employees against any claims arising out of self-administration or lack of administration of this medication by the student.

_____ _____ _____
Parent/Guardian Signature Telephone Date

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

The following section is to be completed by the PHYSICIAN:

Potential life-threatening Diagnosis for which medication is given: _____

Name of medication: _____

Dosage: _____ Route: _____Frequency: _____

If medicine is be given "WHEN NEEDED", describe indications/symptoms: _____
_____

How soon can the medicine be repeated? _____

List significant side effects: _____

Any restrictions or limitations: _____

Date prescribed: _____ Date to be discontinued: _____

I verify that the child above requires this medication and
a. This student has been instructed in and is capable of 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

School District: _____ School Year: _____

Approved By School MD: _____ _____
Signature Date