EAST WINDSOR REGIONAL SCHOOL DISTRICT

DIVISION OF HEALTH SERVICES

Hightstown, New Jersey

AUTHORIZATION FOR SELF-MEDICATION

As the parent/guardian I hereby authorize my son/daughter _____

Print name of child to self-medicate

To carry on his/her person or keep in his/her locker the medication/inhaler and to self-administer the medication prescribed for asthma/ allergic reaction or other potentially life-threatening illness _____

Illness

He/she has been instructed in and understands the purpose, appropriate method and frequency of the use of the medication/inhaler. I consider him/her to be responsible.

I understand that the district will have no liability as a result of any injury arising from the self-administration of the medication by my child and that I indemnify and hold harmless the district and its employees and agents against any claims arising out of the self-administration of the medication.

Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

Physician's Authorization

I certify that _____ is being treated by me for _____

Name of student

which can be a life-threatening illness. He/she is capable of and has been instructed in the proper method of self-administration of the prescribed medication _____ and/or inhaler.

Name of medication

Name of Physician (print or stamp) _____ Physician's signature _____ Date _____

Nurse's Approval

Nurse's signature _____ Date _____

Principal's Approval

I have reviewed the information submitted by you and your child's physician to have your son/daughter carry on his/her person and for keep in his/her locker the prescribed medication/inhaler and to self-medicate him/herself. Your request is granted for the _____-_____ school year. Please be aware that in accordance with N.J.S.A. 18A 40-12.3 c, the district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of the medication by your child. You should also be aware that if during the school year it becomes evident that your child has not demonstrated the ability to properly self-medicate, permission to self-medicate will be revoked. This approval is only for this school year. A new authorization must be submitted annually. If you have any questions please contact the school nurse.

Principal's name (print) _____ Principal's signature _____ Date _____

Note: This form must be completed in addition to the standard medication form required of any student needing medication during school hours/activities, including class trips.

White: student file Yellow: parent/guardian Pink: principal Gold: teacher/coach/trainer

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