AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION

RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

Student Name: _____ DOB: _____ Grade: _____
Emergency Contacts: (Name and Phone#'s):_____
_____

I. Parental/Guardian Consent for Administration of Asthma medication

___**I request that my child be ALLOWED to carry and self-administer in school**, his asthma medication listed below pursuant to N.J.S.A. 18A:40-12.3 and 12.4. I give permission for my child to self-administer his/her medication, as prescribed on this form for the current school year. I consider him/her to be responsible and capable of transporting, storing and self-administrating 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.

___**I do not request that my child self-administer his asthma medication.** I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. 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 administration or lack of administration 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 administration or lack of administration of this medication.

_____ _____ _____
Parent/Guardian Signature Telephone Date

II. Healthcare Provider Order:

Name of medication: _____

Dosage: _____ Route: _____Frequency:_____

For Student Self Administration:
_____This student has been instructed in and is capable of proper method of self-administration of the medication prescribed above.
_____This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.

____This student is **not** approved to self-medicate

_____
Physician's Name Signature Date

Office Stamp:

This form must be individually completed for **all medications**.
Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy.
All medications **will be kept** in a locked storage area.