

SCOTCH PLAINS FANWOOD PUBLIC SCHOOLS

Request for Self-Administration of Medication

CHILD'S NAME _____ GRADE _____

PHYSICIAN'S SECTION

I am requesting that the above named student who has a potentially life-threatening illness be allowed to carry and self-administer the following asthma inhalers as per the prescribed ASTHMA ACTION PLAN.

Name(s) of medications: _____

Possible side effects of medication/or special precautions to be taken: _____

Conditions under which self-administration will take place: (check as many as apply)

_____ **Independently:** Child has been trained and is proficient in self-administering medication and is aware that he/she may not share the medication with anyone else. Medication should be in student's possession. **Students in grade K-2 are not eligible for independent self-medication.**

_____ **Self-administered under the supervision of the school nurse.** (The nurse is on duty during school hours only.) Medication will be kept in the nurse's office.

_____ **Medication will be administered by the nurse.** (The nurse is on duty during school hours only.) Medication will be kept in the nurse's office.

Physician's Name (print or stamp)

Physician's Signature

Telephone Number

Fax Number

Date

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PARENT'S SECTION

I give permission for my child's medications to be administered as ordered in the ASTHMA ACTION PLAN and by the method listed above while on school property or off school property at an approved school event. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician. The medication is to be provided by me in the original labeled container. A duplicate of this medication is to be sent into and kept in the nurse's office. To my knowledge, my child is not allergic to this medication.

I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damages which may result to the student, his/her servants and representatives from administration of the medication provided proper procedures are followed.

Parent/ Guardian's Signature

Date

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STUDENT'S SECTION-for independent self administration only

I understand that I will use my asthma medication as directed by my physician in the ASTHMA ACTION PLAN. I will be responsible and discreet in its use and have it readily available.

I have been instructed how to self-administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shared with anyone else. After each use I will notify the school nurse.

I understand that if I do not abide by these regulations I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of each school year.

Student's Signature

Date

Reviewed by School Medical Director

Date