

SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL SERVICES

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PHYSICIAN AUTHORIZATION

See check off box on bottom left of front page. Indicate if student is permitted to self medicate. Only students in grade 3-12 are eligible to self administer medication.

STUDENT'S SECTION-for independent self-administration grades 3-12 only.

I understand that I will use my medication for asthma as directed by my physician in the ASTHMA TREATMENT 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 _____

Rev: 12/13

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____

Phone _____

Date _____

STUDENT AUTHORIZATION FOR SELF ADMINISTRATION OF ASTHMA MEDICATION

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

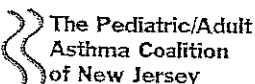
I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C.:8A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. 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/her asthma medication.

Parent/Guardian Signature _____

Phone _____

Date _____



Your Pathway to Asthma Control
PACNJ approved Plan available at
www.pacnj.org

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The Pediatric/Adult Asthma Coalition of New Jersey is sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U55CE000181-01. Its content are solely the responsibility of the author and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA87230982-4 to the American Lung Association in New Jersey, it has not gone through the Agency's publication review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For advice or any medical condition, seek medical advice from your child's or your health care professional.

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