

PARENT/GUARDIAN PERMISSION FOR MINOR STUDENT TO SELF-ADMINISTER MEDICATION

I, the parent/guardian of _____ authorize my child, a pupil at The Wardlaw+Hartridge School to self-administer medication prescribed by our physician as described below for a life-threatening condition. Such Medication is generally limited to Asthma Inhaler, pre-filled Epinephrine auto-injector with or without a unit dose of Benadryl, and Diabetic Care/Medications. I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. I further understand that neither The Wardlaw+Hartridge School employees or nurse, and/or ESCNJ's employees or nurse shall be responsible for any liability as a result of any injury arising from the self-administration of this medication by my child, or misuse of the medication. I agree that this information will be shared on a need to know basis with school personnel. All medications must be non-expired and be brought to school in an original, unopened labeled pharmacy container, including for over-the-counter medications.

Parent/Guardian Signature _____ print name _____ Date _____

(**See other side**) 2-sided document 18 and over must sign this form

PHYSICIAN'S AUTHORIZATION/ASSURANCE STATEMENT FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION

I certify that _____ is under my care for a life-threatening condition. I am recommending that the above-named student be permitted to self-administer medication. He/She is capable of, and has been instructed by me in the proper method of self-administration of the following medications: (Such medication is generally limited to Asthma Inhaler, pre-filled Epinephrine auto-injector with or without a unit dose of Benadryl, and IDDM meds)

Name and Purpose of Medication: _____

Identification of life-threatening medical problems: _____

Prescribed dosage/route/schedule: _____

Length of time medication to be taken: _____

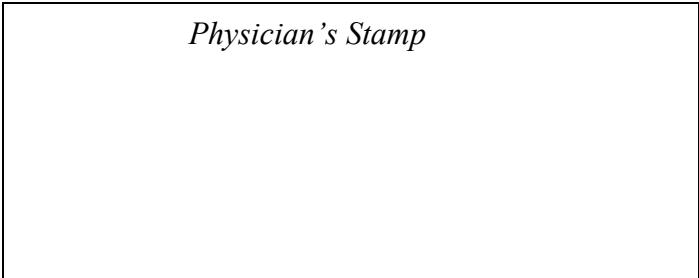
Possible side effects and/or special precautions: _____

Prescribing Physician's Signature

Please print name and address of Prescribing Physician

Telephone # _____ date _____

NEITHER THE WARDLAW+HARTRIDGE SCHOOL NOR ANY EMPLOYEE OR NURSE, NURSE'S AGENTS/EMPLOYER, ESCNJ NURSE(S) SHALL BE RESPONSIBLE FOR ANY LIABILITY AS A RESULT OF ANY INJURY TO THE ABOVE-NAMED STUDENT, ARISING FROM THE SELFADMINISTRATION OF MEDICATION OR ANY MISUSE OF THE MEDICATION.



Parent Form (see other side; 2-sided document**)**

Self-Administration Policy & Release

Students who self-administer must be authorized to do so **in writing** by their doctor and parent, and as approved by school nurse. See school nurse for forms. “Self-Administrators” are responsible to carry and self-administer their approved medications **with them at all times**. This includes before, during, and after school, as well as **any and all** school functions, performances, trips, clubs, activities, or sports events. The medication(s) the student’s doctor orders must be sent with the student daily **from home**. As a parent, you agree to oversee that your student has the **appropriate, un-expired, properly pharmacy labeled** medications with them daily. Parent agrees to share this policy, review this policy with your child. Student and parent agree not to share his/her medications with anyone. Furthermore, all agree the student will tell the person in charge of the school event they have taken medication. The school nurse should also be informed when available. Student must seek adult help immediately at any time he/she needs to, or if there is a problem or concern, as well as seek out school nurse with questions.

We agree to indemnify and hold harmless the Wardlaw+Hartridge School, its employees/agents; and school nurse/nurse’s employer(s), ESCNJ’s employees/nurse(s) from any claims arising from failure of parent or student following this policy/procedure.

I understand and have instructed my child, along with his or her doctor’s guidance, in proper use, storage, and administration of the prescribed medication(s). I will only send in the prescribed amount needed.

Self-administrators are also required to keep a “back-up” set of medications in the nurse’s office for emergency use (while still carrying a set of their “own” medications with them daily).

Student Name _____

Parent/Guardian print name _____

Parent/Guardian signature _____