CHERRY HILL SCHOOL DISTRICT

Authorization for Self-Administration of
Asthma Inhaler/ Epinephrine/ Hydrocortisone Sodium Succinate by Student

School Year: _____ Grade: _____

Date: _____ ☐ Asthma ☐ Life Threatening Allergy ☐ Adrenal Crisis

Student: _____

Date of birth: _____

The minor individual named above is my patient. I understand that this patient is a student in your school district.

I further understand that pursuant to the provisions of N.J.S.A. 18A:40-12.3 allows the parent(s) or guardian(s) of a student who has asthma, a potentially life-threatening allergy or adrenal crisis to authorize self-administration of an asthma inhaler, epinephrine or hydrocortisone sodium succinate by the student providing the student's physician certifies to the school district that the student is capable of, and had been instructed in, the proper method of self-administration of this medication.

My patient has asthma, a known allergy and is at risk for a life-threatening reaction or is at risk for adrenal crisis requiring the use of an asthma inhaler, epinephrine auto-injector or hydrocortisone sodium succinate.

My patient is capable of, and has been instructed in, the proper method of self-administration of an asthma inhaler, epinephrine auto-injector or hydrocortisone sodium succinate. In the event that the medication which I have prescribed is changed in the future, I will either assure that my patient remains capable of, and has been instructed in the proper method of self-administration of said medication, or will notify the school district that my patient is no longer capable of, or has not been instructed in, the proper method of such self-administration.

I understand that the authorization by my patient's parent(s) or guardian(s) is ***effective only for the current school year*** and must be re-authorized by them for each future school year. Any such re-authorization by my patient's parent(s) or guardian(s) for any future school year must be accompanied by a new certification by me.

Medication: _____

Physician's Signature: _____

Physician's Name (print): _____

Phone Number: _____

Date: _____

Physician's Stamp

"Physician" refers to all Health Care Providers licensed as MD, DO, APN, and PA

COMPLETE BOTH SIDES

Revised 5/2020