FREEHOLD REGIONAL HIGH SCHOOL DISTRICT

REQUEST FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

Student Name: _____ School: _____Grade: _____

Date of Birth: _____ Age: _____ ID#: _____

As per Board Policy and Regulation 5330, self-administration of medication by a student may be permitted for the treatment of asthma or other potentially life threatening illness, or a life threatening allergic reaction. A life threatening illness is defined as an illness or condition that requires an immediate response to specific symptoms and/or an after effect of disease or injury that if left untreated may lead to potential loss of life. All requests for self administration of medication are effective for one school year only and expire as of July 1st of each year.

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SECTION ONE: To be completed by student's Private Physician

I certify that the student named above has a qualifying condition or illness that may require medication. I certify that the student has been instructed and is proficient in the proper method of self-administration of the prescribed medication, and is capable of self-carrying and self administration of the prescribed medication. I hereby request that the above named student be allowed to self-administer the following medication as prescribed by me:

Name of Medication: _____ Form of medication: _____

Diagnosis/Reason: _____ Purpose of medication: _____

Dosage: _____ Frequency: _____

Time Medication to be Self-Administered:_____

Special Instructions: _____

_____

Possible Side Effects: _____

_____

Date to Begin: _____ Date to Conclude:_____

_____ _____

Physician's Name (Printed/Typed) Address

_____ _____ _____

Physician's Signature Date Telephone Number
(Stamp not acceptable)

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SECTION TWO: To be completed by Parent(s)/Guardian(s)

I/We, as parent/guardian of _____, provide our express authorization and permission for _____ to self-administer _____ while in school and/or during school activities/athletics.

In accordance with Board Policy and Regulation 5330 and N.J.S.A. 18A:40-12.3, I/we have been advised, understand and acknowledge that the Board, the District and any of its employees or agents shall have no liability as a result of any injury to my child that is caused by or arises out of the self-administration of any medication.

I/We further understand and acknowledge that in accordance with N.J.S.A. 18A:40-12.3, I/we must indemnify and hold harmless the Board, the District and any of its employees or agents against any claims arising out of the self-administration.

I/We understand and acknowledge that the permission provided by this form is good for the current school year only and must be renewed for each subsequent school year.

_____ _____ _____

Signature of Parent/Guardian Date Emergency Telephone number

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SECTION THREE: To be completed by school staff

After consultation with the School Nurse and School Medical Inspector, the request for self administering of medication by the student referenced above is hereby [**GRANTED/DENIED**] (select one).

_____ _____

Signature of School Principal Date

A copy of this completed form will be provided to the School Nurse and the student's parent(s)/ guardian(s).

In accordance with Board Policy and Regulation 5330, any request that is denied may be appealed to the Superintendent or his/her designee.