PENNSAUKEN PUBLIC SCHOOLS **APPENDIX A-2**

REQUEST FOR SELF ADMINISTRATION

(APPLICABLE *ONLY* TO INHALERS AND EPINEPHRINE VIA AUTO INJECTORS)

STUDENT'S NAME _____ DOB: _____ DATE: _____

SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN NAME: _____ TELEPHONE: (home) _____
(work) _____

To Be Completed by Physician: (Please Print)

I am recommending that the above named student be permitted to self administer the following medication:

Identification of Chronic Medical Problem:

_____

Name and Purpose of Medication

_____

Prescribed Dosage and Schedule:

_____

Length of Time Medication be taken:

_____

Possible Side Effects and/or Special Precautions:

_____

Child has been instructed by me and is proficient in self-administration of the above medication.

_____ _____
Physician's Name (Print) Physician's Signature

_____ _____
Telephone Date

To Be Completed By Parent/Guardian:

I give my permission for my child to self administer the medication described above. I will notify the school nurse if this medication is no longer required or if self administration is no longer directed by the physician.

_____
Parent/Guardian Signature Date

Liability Release Statement:

Having requested that my child self administer his/her medication, I shall indemnify and hold harmless the School District and its employees and agents against any claims that arise out of this self medication recommendation.

_____
Parent/Guardian Signature Date