

ST. THOMAS AQUINAS HIGH SCHOOL
ONE TINGLEY LANE • EDISON, NJ 08820

Office of the Principal

Sr. Donna Marie Trukowski, C.S.S.F.

PARENTAL CONSENT FORM

I hereby acknowledge my understanding that if procedures specified in the "Emergency Plan for Allergic Reactions" for the administration of Epinephrine by a delegate trained by the nurse are followed, St. Thomas Aquinas High School shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose auto injector mechanism containing epinephrine to the pupil and that the parents or guardians shall indemnify and hold harmless St. Thomas Aquinas High School and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to a pupil.

I also understand that this "Emergency Plan for Allergic Reactions From" is good for this school year only. A new form is required each year.

Parent/Guardian Signature

Date

St. Thomas Aquinas High School

ONE TINGLEY LANE • EDISON, NJ 08820

Nurse's Office

Dear Parent/ Guardian:

The State of New Jersey passed legislation allowing students to carry medication for asthma or other potentially life-threatening illnesses: i.e. an inhaler or an ANA kit provided that:

1. The parents or guardians of the student provide the school with written authorization for self-administration of the medication.
2. The school receives written certification from the physician of the student that the student has asthma or other life-threatening illnesses.
3. The physician certifies that the student is capable of, and has been instructed in, the proper method of self-administration.
4. The parents or guardians of the student sign a statement acknowledging that the school shall incur no liability as a result of any injury arising from self-administration of the medication by the pupil and that the parents or guardians shall indemnify and hold harmless the school and its employees or agents against any claims arising out of the self-administration of the medication by the pupil as in the past.

The school and its employees or agents shall incur no liability as a result of any injury arising from self-administration of medication by the student.

The permission is effective for one school year and must be renewed annually.

This provision is for students with inhalers for asthma and medication for life-threatening illnesses only. All other medications will be kept in the Nurses Office and dispensed with a written order and parental permission as in the past.

Sincerely,

School Nurse

St. Thomas Aquinas High School
ONE TINGLEY LANE • EDISON, NJ 08820

Nurse's Office

**PHYSICIAN REQUEST FOR STUDENT WITH LIFE THREATENING CONDITION
TO SELF ADMINISTER MEDICATION**

STUDENT MUST CARRY MEDICATION AT ALL TIMES

NAME OF STUDENT: _____ GRADE: _____ ID# _____

DIAGNOSIS / ILLNESS: _____

MEDICATION #1: _____ DOSAGE: _____

FREQUENCY: _____ METHOD OF ADMIN: _____

SIDE EFFECTS: _____

MEDICATION #2: _____ DOSAGE: _____

FREQUENCY: _____ METHOD OF ADMIN: _____

SIDE EFFECTS: _____

I certify that I have instructed this child in the proper method of administration and certify that the child is capable of self-administration and has demonstrated this to my satisfaction. I assume responsibility for the child's safety in self-administration.

Physician Signature
(Counter stamps are not accepted)

Phone #

Date

* I/We authorize the Principal, School Nurse and the school's employees to permit the student to self-administer the above medication/s as indicated. I/We understand and agree that the Principal, School Nurse, and the school's personnel shall not be liable for any injury to the Student resulting from the self-administration of the medication/s as authorized by the signature below.

* I assume full responsibility for providing the above named medication in a clearly labeled, original container.

* I acknowledge that I may be liable if any other child is injured by the inadvertent use of this medication.

STUDENT MUST CARRY MEDICATION AT ALL TIMES

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature and may be shared with school personnel if necessary to assure the health of the student.

Signature of Student

Signature of Parent /Guardian

Date

Date

EMERGENCY HEALTH PLAN

Name _____ ID# _____ Date _____

Diagnosis _____ Allergy _____

Physician's Name _____ Phone: _____

Student - Specific Emergencies

<i>If You See This</i>	<i>Do This</i>

If an emergency occurs at a time or place other than normal school hours:

1. Call 911 Immediately if life threatening
2. Stay with student or designate another adult to do so.
3. Give prescribed medication if available.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911

Medication: _____ Dosage _____ Method of Admin: _____

Medication: _____ Dosage _____ Method of Admin: _____

Instructions:

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature and may be shared with school personnel if necessary to assure the health of the student.

Parent Signature *Date*

Physician Signature *Date*

Emergency Contacts (*please print*)

1. Name: _____ Relationship: _____

Phone#1: _____ Phone #2 _____

2. Name: _____ Relationship: _____

Phone#1: _____ Phone #2 _____

3. Name: _____ Relationship: _____

Phone#1: _____ Phone #2 _____