Community School Health Information 2025-2026

Enclosed you will find school medical forms that must be returned **prior to the start of the new school year.** All may not apply to your child, but those that do are required by New Jersey State Law to be on file in the School Health Office.

Please download and print out the following health forms that are applicable to your child.

Please note the following:

- **All parents/guardians** must complete the Community School ***Health Appraisal Parent/Guardian Questionnaire.***

  Health Appraisal Parent-Guardian Page 3.doc

- In addition to the state required immunizations, ***please note that students who are in 6th grade and/or 11 years old must submit proof that they have received the Meningococcal and Tdap vaccines prior to starting the new school year.***

- If your child:
  1. Will be taking ***Medication at school*** (Prescription and/or Over the Counter meds)
  2. Has been diagnosed with ***Asthma***
  3. Has been diagnosed with ***Severe allergies and has an EpiPen***
  4. Has been diagnosed with a ***Seizure disorder***

You will find additional Medical Forms (on the following pages) that will need to be completed by your child's health care provider.

Student Medications:

*Authorization to Administer Prescription Medication in School

This form is required to be completed and signed by the Prescribing Physician and the Parent/Guardian if your child will require medication to be administered while in school.

Authorization to Administer Prescription Medication in School page 5.doc

Please Note:

- When possible, Medication should be sent to school with a responsible adult.
- Medication **must be sent in the original labeled pharmacy container**.
- All Medication will be kept in the Health Office and you will be notified when a new supply is needed.
- Medications should be picked up at the end of the school year (by a responsible adult if possible) or medication will be sent home by mail from the school.

*Authorization to Administer Prescription Medication (usually taken at home)

This form is required to be completed and signed by both the Prescribing Physician and the Parent/Guardian if you are leaving a small supply of medication for an am missed dose at home.

Authorization to Administer Prescription Medication Taken at Home Page 6.doc

Please Note:

- Please notify the school nurse by phone or email to verify that the dose has been missed.
- When possible, Medication should be sent to school with a responsible adult.
- Medication **must be sent in the original labeled pharmacy container**.
- Medications should be picked up at the end of the school year (by a responsible adult if possible) or medication will be sent home by mail from the school.

***Over the Counter Medications** – Occasionally your child may need an Over the Counter Medication (Tylenol, Advil, Cough/Throat drop, Tums) and these are available in the Health Office. The *Over the Counter Medications* consent form is required to be completed and signed by both the parent/guardian and physician for medication to be given.

Authorization for Over-The Counter Medication Page 7.docx

Students with Asthma:

1) For Treatment of Asthma – If your child has asthma and uses an inhaler and/or nebulizer this CS form is required to be completed and signed by the prescribing physician and the parent/guardian. This form is required for all students with a prescribed inhaler whether the medication is kept in the Health Office or the student carries their own.

Authorization for Treatment of Asthma 2020-2021.docx

2) Asthma Treatment Plan – This form is required by New Jersey State Law to be kept on file for any student who has asthma. This plan will need to be completed and signed by the prescribing physician and the parent/guardian. This form is required for all students whether their medication is kept in the Health Office or the student carries their own.

Asthma Treatment Plan Page 8&9.pdf

Students with an Epi Pen:

1) For Treatment of Anaphylaxis via EpiPen If your child has life threatening allergies and has been given an EpiPen, this CS form is required to be completed and signed by the prescribing physician and the parent/guardian. This form is required for all students with a prescribed EpiPen whether the medication is kept in the Health Office or the student carries their own.

Authorization for Treatment of Anaphylaxis Via Epi-Pen 2020-2021.doc

2) The Food Allergy Action Plan This form is required by New Jersey State Law to be kept on file for any student who has been prescribed an Epi-Pen. This plan will need to be completed and signed by the prescribing physician and the parent/guardian. This plan is required for all students whether their medication is kept in the Health Office or the student carries their own.

Food Allergy Action Plan Page 11&12.pdf

Students with a Seizure Disorder:

****Please contact the School Nurse for a copy of the***

1) *Seizure Action Plan*

2) Parent Questionnaire.

FOR NEW STUDENTS ONLY

New students must obtain the following from their medical doctor:

1. A copy of their most recent **Physical Exam** (***completed within the last 365 days***).
2. A copy of their current **Immunization Record**.

These medical records are required as per NJ Law and must be submitted **before** the students' first day of school. **In order for a student to participate in Physical Education, a physical must be on file.**

Health Appraisal-Parent/Guardian Questionnaire
TO BE COMPLETED BY PARENT/GUARDIAN

Student: _____

DOB: _____ Date: _____

Does your son/daughter have any medical issues and/or concerns? **YES** _____ **NO** _____

_____
_____
_____

Are there any special precautions, limitations and/or special alerts that the school should take regarding your son/daughter's health? **YES** _____ **NO** _____

_____
_____
_____

Is permission given for your son/daughter to participate in a regular physical education program? (Indicate any restrictions) **YES** _____ **NO** ____

_____
_____
_____

Does your son/daughter have asthma? **YES** _____ **NO** _____

If yes, please list medications: _____

Does your son/daughter have any allergies or sensitivities?
(Include any food allergies or sensitivities) **YES** _____ **NO** _____

_____
_____
_____

If yes, does your son/daughter have a prescribed epi pen? **YES** _____ **NO** _____

Is your son/daughter currently on medication? **YES** _____ **NO** _____

If yes, please list:

_____
_____
_____

Please be sure to contact the school when this medication is changed or no longer being used.

Parent/Guardian signature _____

2025-2026

The Community School – Phone: 201-837-8070 Fax: 201-837-6799

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION USUALLY TAKEN AT HOME

2025-2026

NAME OF CHILD: _____

DATE OF BIRTH: _____

NAME OF MEDICATION: _____

DOSAGE: _____

FREQUENCY GIVEN & DIRECTIONS (frequency route/time of administration):

_____

_____

PURPOSE OF DRUG: _____

POSSIBLE SIDE EFFECTS: _____

_____

I authorize the School Nurse or her designated substitute in the event she is absent to administer the above medication to my child during school or at school related activities in the event that my child has missed his/her dosage normally taken at home or has had to remain at school due to unforeseen circumstances and/or has been unable to travel home.

I understand that the Community School, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; that I will indemnify and hold harmless the Community School, school nurse and other school employees against any claims arising from the administration to my child.

I agree to update this form and to so inform the school whenever my son/daughter's medication needs might change each time when such change might occur during the course of the school year.

_____ _____

(Signature of M.D.) (Parent's Signature)

_____ _____

(Address) (Date)

_____ _____

(Phone No.) (Physician's Stamp)

This permission is effective for the current school year only and must be renewed annually.

THE COMMUNITY SCHOOL, INC.
11 West Forest Avenue, Teaneck, New Jersey 07666
(201) 837-8070 Fax: (201) 837-6799

OVER -THE -COUNTER MEDICATIONS
MUST be signed by your physician

Because the school is often unable to reach parents by phone to grant permission for the school nurse to dispense certain non-prescription medications requested by the student, parents may request that the school nurse administer these specific over-the-counter medications at the student's request.

If after reading the conditions noted, you request that the school nurse be granted permission to administer these over-the-counter medications to your son/daughter, please complete below and have your physician sign so that we may have your permission on file for the **2024-2025** academic year.

Thank you.

Student: _____ DATE: _____

By granting permission for the school nurse to administer the specific over-the-counter medications (as noted below), I have confirmed with our physician that my child may take the medications checked below. **Our physician has signed below noting this confirmation.**

In doing so, we agree that the Community School shall incur no liability as a result of any injury arising from the dispensing of the over-the-counter medications and we further agree to indemnity and hold harmless the Community School and its employees or agents against any claims arising out of the administration of the over-the-counter medication.

Please check A or B. If A is checked please indicate which over-the-counter medications are acceptable.

□ **A. Permission is hereby granted for Community School to administer the following In the age/weight appropriate dose at the student's request (check all applicable).**

□Tylenol/Advil □Halls Cough/Throat Drops □Benadryl □Tums

□ **B. Do not administer any over-the-counter medications under any circumstances.**

Signed: _____ Physician's Name: _____
(Parent)
Physician's Signature and Stamp: _____

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by American Lung Association in New Jersey

NJ Health New Jersey Department of Health

(Please Print)

Name	Date of Birth	Effective Date

Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY (Green Zone)

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.

Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ❍ Dust Mites, dust, stuffed animals, carpet
  - ❍ Pollen - trees, grass, weeds
  - ❍ Mold
  - ❍ Pets - animal dander
  - ❍ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ❍ Cigarette smoke & second hand smoke
  - ❍ Perfumes, cleaning products, scented products
  - ❍ Smoke from burning wood, inside or outside
- ❑ Weather
  - ❍ Sudden temperature change
  - ❍ Extreme weather - hot and cold
  - ❍ Ozone alert days
- ❑ Foods:
  - ❍ _____
  - ❍ _____
  - ❍ _____
- ❑ Other:
  - ❍ _____
  - ❍ _____
  - ❍ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U58EH000401-5. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

REVISED MAY 2017

Permission to Self-administer Medication:

- ☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- ☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE_____

Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

OVER

Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: *Before taking this form to your Health Care Provider,* complete the top left section with:
- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

2. Your Health Care Provider will complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

PACNJ Pediatric/Adult Asthma Coalition

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-5. Its content are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Sponsored by
AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

Community School- Fax # 201-837-6799
2025-2026

Authorization for Self-Administration Or Assisted Administration of Medication

FOR TREATMENT OF ASTHMA

To be completed by the parent (please print or type):

Child's Name _____ _____ _____
Last *First* *Date of Birth*

_____ _____ _____
Physician's Name *Address* *Phone #*

I request that my above named child, as authorized by the physician below, either be permitted to self-administer or be assisted in the administration of the medicines indicated below by authorized persons at Community School. I understand and agree in making this request that neither Community School nor its staff shall incur any liability as a result of any injury/reaction arising from the self-medication or assisted medication, and agree to indemnify and hold harmless the Community School and its employees or agents against any claims arising out of the administration of the medication. This permission is effective for the current school year.

_____ _____ _____ _____
Date *Parent/Guardian Signature* *Home Phone* *Emergency Phone*

The following must be completed by the Physician:

Diagnosis _____

Medication _____

Form _____ Dose _____

If given daily, what time? _____

If PRN _____

Describe indications _____

How soon may it be repeated? _____

List significant side effects _____

Length of time this treatment is recommended _____

Is child authorized to self-medicate? _____

Other information _____

Date _____ Physician's Signature _____
Physician's Stamp

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

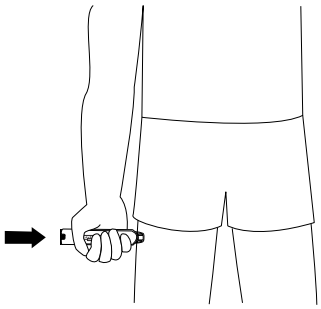
TURN FORM OVER

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

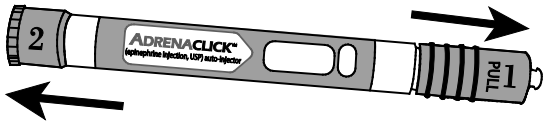
- **Hold orange tip near outer thigh (always apply to thigh)**



- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

Community School – Fax # 201-837-6799
2025-2026

Authorization for Self-Administration Or Assisted Administration of Medication

FOR TREATMENT OF ANAPHYLAXIS VIA EPI-PEN (EPINEPHRINE)

To be completed by the parent (please print):

Child's Name _____ _____ _____
Last *First* *Date of Birth*

_____ _____ _____
Physician's Name *Address* *Phone #*

I request that my above named child, as authorized by the physician below, either be permitted to self-administer or be assisted in the administration of the medicines indicated below by authorized persons at Community School. I understand and agree in making this request that neither Community School nor its staff shall incur any liability as a result of any injury/reaction arising from the self-medication or assisted medication, and agree to indemnify and hold harmless the Community School and its employees or agents against any claims arising out of the administration of the medication. This permission is effective for the current school year.

_____ _____ _____ _____
Date *Parent/Guardian Signature* *Home Phone* *Emergency Phone*

The following must be completed by the Physician:

Diagnosis _____

Medication _____

Form _____ Dose _____

Describe indications _____

How soon may it be repeated? _____

List significant side effects _____

Length of time this treatment is recommended _____

Is child authorized to self-medicate? _____

Other information _____

Date _____ Physician's Signature _____
Physician's Stamp