



# Manville School District

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**Weston Elementary School**  
600 Newark Avenue  
Phone: 908-231-8550  
Fax: 908-530-2334

**Roosevelt School**  
410 Brooks Boulevard  
Phone: 908-231-6810  
Fax: 908-231-1881

**A.B.I.S.**  
100 N. 13th Avenue  
Phone: 908-231-8530  
Fax: 908-393-7319

**Manville High School**  
1100 Brooks Boulevard  
Phone: 908-231-8520  
Fax: 908-231-8532

## Healthcare Provider Authorization for Student Use of an Inhaler Valid for Current School Year Only

### HEALTH CARE PROVIDER: CHECK ONE:

The named student has been trained to self-administer their inhaler. The student has demonstrated the ability to recognize their need for the medication, and can administer the medication safely and properly.

Or

The student is not capable of self-administration at this time and must report to the school nurse for medication administration

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Medication:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Adverse reactions that may occur:** \_\_\_\_\_

**Name of Healthcare Provider (print):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Healthcare Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Healthcare Provider Stamp (required):**

### Parent/Guardian Medication Request Section – To be completed by the Parent/Guardian.

I hereby give permission for my child to self-administer the above medication at school as prescribed above by my child's healthcare provider. I also give permission for the release and exchange of information between the school nurse and my child's healthcare provider concerning my child's health and treatment. I understand that neither the district nor any of its employees shall be liable for any injury resulting from self-medication, and I agree to indemnify and hold harmless the district and its agents against any related claims. I am aware that self-management privileges may be lost if the procedure is not followed properly.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Requests are effective for one school year only and must be renewed annually or when there is any change in prescription.