



UNION COUNTY VOCATIONAL - TECHNICAL SCHOOLS

1776 Raritan Road, Scotch Plains, New Jersey 07076-2997
(908) 889-8288 Ext. 405 Fax: (908) 889-1599 www.ucvts.org
Nurse's Office

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

1. MEDICATION TYPE

Asthma Inhaler Epinephrine Auto-Injector (Allergy Kit)

2. STUDENT INFORMATION

Full Name: _____

Date of Birth: _____

School: AAHS / AIT / APA / MHS / UCCTI / UCT/AGL

Grade: _____

3. PHYSICIAN'S CLINICAL AUTHORIZATION

I request that the above student be permitted to carry and self-administer the following:

- **Diagnosis:** _____
- **Medication Name:** _____
- **Prescribed Dosage:** _____
- **Timing/Frequency:**
 - **Fixed Schedule:** Time(s): _____
 - **PRN (As Needed):** Indications: _____
 - *Repeat interval (if needed):* _____
- **Side Effects/Precautions:** _____
- **Prescription Expiration:** _____

4. ADMINISTRATION PROTOCOL

Please select the level of student responsibility:

Independent Carry & Administer

The student has been trained and is proficient in self-administration. They understand they **may not** share this medication. Medication will be kept on the student's person.

Supervised Administration

Medication will be stored in the School Nurse's office and administered under professional supervision.

5. AUTHORIZATION SIGNATURES

Physician Name (Stamp): _____

Physician Signature: _____

Phone Number: _____

Date: _____



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Parental Request for Self-Administration of Medication

Section 1: Parental Authorization & Liability Release

I, the parent/guardian, authorize the following for my child, _____:

- **Grant Permission:** I authorize my child to carry and self-administer the medication prescribed on Page 1 during school hours and school-sponsored events.
- **Acknowledge Safety:** I confirm that my child has no known allergies to this medication.
- **Maintain Supply:** I will provide the medication in its **original pharmacy-labeled container** and will supply a duplicate to be stored in the School Nurse's office.
- **Report Changes:** I will notify the school nurse immediately if this medication is discontinued or if the physician modifies the self-administration orders.
- **Release Liability:** I hereby release and hold harmless the Board of Education and its employees from any liability for injuries or damages resulting from the self-administration of this medication.

Date: _____

Parent/Guardian Signature: _____

Section 2: Student Medication Contract

I, the student, agree to the following safety protocols:

1. **Follow Medical Advice:** I will use _____ (Medication Name) exactly as my doctor prescribed.
2. **Ensure Safety:** I will keep my medication in its **original labeled container** and will **never share** it with another person.
3. **Maintain Access:** I will keep my medication readily accessible and use it responsibly and discreetly.
4. **Report Usage:** I will notify the school nurse as soon as possible after each time I use this medication.
5. **Confirm Training:** I have been trained by Dr. _____ on proper administration and understand the risks of improper use.

Agreement: I understand that violating these rules may result in the loss of my privilege to carry and self-administer medication. I will renew this contract at the start of every school year.

Student Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

