

CALIFON PUBLIC SCHOOL
Request for Self Administration of Medication

Asthma Inhalers/Epi Pen

Student's Name: _____ Date: _____ D.O.B.: _____

Parent/Guardian Name: _____

Telephone: (Work) _____

(Home) _____

To Be Completed By Physician: (PLEASE PRINT)

I am requesting *that* the above named student be allowed to self-administer medication as follows:

1. Name of Medication: _____

2. Diagnosis for which medication is prescribed: _____

3. Dosage and time to be taken: _____

4. Possible side effects and/or special precautions to be taken: _____

5. Length of time this medication is to be taken: _____

6. Conditions under which self-administration will take place:

_____ Independently - Child has been trained and is proficient in self- administering medication.

_____ Under the supervision of nurse.

7. Medication should be:

_____ Stored in the school health office or designated area.

_____ Kept in the possession of the student.

Physician's Name (PRINT)

Physician's Signature

Physician's Telephone Number

Date

To be completed by Parent or Guardian: I give my permission for my child to self-administer the medication described above. I will notify the school health office if this medication is no longer required or self-administration is no longer directed by the physician.

Califon Public School and its employees/agents, shall incur no liability as a result of any injury arising from the self administration of medication by the pupil, and the parents or guardians shall indemnify and hold harmless the school and its employees or agents and claims arising out of the self-administration of medication by the pupil. Permission is effective for the school year for which it is granted and is renewed for each subsequent school year upon fulfillment of the requirements listed above.

Parent's/Guardian's Signature

Date