THE PUBLIC SCHOOLS
WEST ORANGE, N.J. 07052

**Department of Student Support Services** **Health Services**

## SELF-ADMINISTRATION OF MEDICATION

Dear Parent/Guardian:

Please be advised that the West Orange Board of Education has adopted a policy providing for student self-medication. The policy sets forth specific conditions under which a student may be permitted to carry and to use, in an emergency, medication.

You must provide the school nurse with written authorization for the self-administration of medication.

You must provide the school nurse with written certification from the physician of the pupil that the pupil has asthma or other potentially life-threatening illness and is capable of, and has been instructed in, the proper method of self-administration of medication.

You must sign the attached waiver which informs parents or guardians of the pupil that the district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medications by the pupil.

All documentation must be given to the school nurse before the student may be permitted to carry and use emergency medication.

Please return the attached waiver and the medical authorization form to me within fourteen days of the receipt of this letter.

_____ _____

School Nurse Date

H-96-57

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# PHYSICIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

The following sections are to be completed by a physician

**Section I**

**Name of Student** _____

**Birth Date** _____ **School** _____ **Grade** _____

I certify that the above named student has a potentially life-threatening illness and is capable of, and has been instructed in, the proper method of self-administration of the medication(s) listed below:

**Physician's Signature** _____ **Date** _____

**Section II**

A. Diagnosis for which medication(s) is/are to be taken _____

_____

B.

| | Medication | Dosage | Frequency | Major Side Effects |
|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |

C. How long has student been taking above medication(s)?

1. _____

2. _____

D. Other information or comments about student or medication:

_____

_____

Physician's Signature _____ Date _____

Physician's Stamp _____ Telephone _____

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## PARENTAL PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

I give permission for _____ to self-medicate for asthma or other potentially life-threatening illness for school year 19_____ to 19_____.

Signed: _____ Date: _____
Parent/Guardian

## MEDICATION WAIVER

This acknowledges that the district shall incur no liability as a result of any injury arising from the self-administration of medication by _____ and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication.

Signed: _____ Date: _____
Parent/Guardian

H-96-58