EWING PUBLIC SCHOOLS

Self-Administration of Medication Request

Pupil _____ Date of Birth _____

Grade _____ School _____

To be completed by private physician / nurse practitioner per NJ state law:

I certify that it is essential to the health of the above named pupil that the following medication be self-administered during school hours as directed. The pupil is physically fit to attend school and is free of contagious disease. The pupil is proficient in self-administering the prescribed medication and has been taught how and when to properly use it.

I hereby request that the above named pupil be allowed to self-administer the following medication as prescribed by me:

Diagnosis: _____

Medication: _____

Route of administration: _____

Dosage: _____

Time of administration: _____

Side effects: _____

Date to begin: _____ Date to conclude:_____

Pupil instructed as to use: _____yes ____no

Medication should be: ____in possession of pupil at all times
____stored in school health office
____in possession of pupil on class trips

_____ _____
Physician Signature Date of Signature

_____ _____
Printed Name of Physician Phone Number

To be completed by parent/guardian:

I give my child permission to self-administer this medication for any life threatening illness. My child is capable of using this medication alone, and has been taught how and when to use it. The school district, the board of education, and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of this medication by my child. I will indemnify and hold harmless the district and its employees or agents against any claims arising out of self-administration of medication by my child.

I will supply the medication in its original container. I will notify the school nurse if this medication is no longer required or if self-administration is no longer directed by the physician.

I grant permission to share this health information with those staff members responsible for the care of my child.

_____ _____
Signature of Parent/Guardian Date

_____
Phone Number

To be completed by staff:

_____ _____
School Nurse Signature Date

_____ _____
School Physician Signature Date