Millburn Township Schools

Department of Special Services

SELF-ADMINISTRATION OF MEDICATION

Dear Parent(s)/Guardian(s):

Please be advised that the Millburn Township Board of Education policies and regulations (Policies 5530, 5532, 5535) provide for student self-medication in specific conditions under which a student may be permitted to carry and to use, in emergencies, an inhaler or auto-injector. These conditions are:

A licensed physician must certify that your child suffers from a potentially life-threatening condition requiring the immediate use of an inhaler or an auto-injector.

The physician must also certify that your child is capable of self-administration of the inhaler or auto-injector without supervision.

An identical copy of an inhaler or auto-injector that your child is permitted to carry may be retained in the school nurse's office. The inhaler or auto-injector will be provided by the parent(s)/guardian(s).

You must sign the attached waiver, which releases, indemnifies and holds harmless the board of education against any and all liability for damage or injury in association with your child carrying and using an inhaler or auto-injector.

Should you wish to have your child self-medicate, it is critical that you advise him/her that only he/she may carry or use the inhaler or auto-injector. It may not be shared with anyone else.

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

The permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of the requirements.

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Date:_____School: _____

Please have your child's physician complete this form regarding self- administration of your child's medication during school time. This form must be signed by a parent/guardian and returned to the office of the school nurse. If you have any questions, please call the nurse's office.

Thank you for your cooperation in completing this form.

Student_____ Grade_____

SECTION I: TO BE COMPLETED BY PHYSICIAN:

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.

Diagnosis_____

1. Medication_____ Dosage_____

Conditions when student will need medication_____

_____

2. Medication_____Dosage_____

Conditions when student will need medication_____

_____

Does student experience any side effects of medication? Yes_____No_____

If YES please explain_____

Comments:_____

Physician's
Signature_____Telephone#_____Date_____

Physician's Stamp_____

SECTION II: TO BE COMPLETED BY PARENT/GUARDIAN

I give my permission for my child to self-administer the medication(s) described above. I will notify the school nurse if this medication(s) is no longer required or self-administration is no longer directed by the physician.

Parent/Guardian Signature _____Date _____

Date received by nurse_____

MEDICATION WAIVER: I acknowledge that the district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by_____and indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication.

_____Date_____

Signature of Parent/Guardian