FORM C

INSTRUCTIONS for SELF-ADMINISTRATION of MEDICATION for ASTHMA, POTENTIALLY LIFE-THREATENING ILLNESS or LIFE-THREATENING ALLERGIC REACTION

This includes permission for student to use/ carry metered dose inhalers or other medications for asthma, potentially life-threatening illness or a life-threatening allergic reaction.

Immaculate Heart Academy's policy in compliance with New Jersey law requires the following conditions be met for a student to self-administer medication during school hours:

1. Written authorization is required from parent/guardian and the student's health care professional for the self-administration by your child of the listed medication. Self-administration is only permitted for medications treating **asthma,** a ***diagnosed potentially life-threatening condition or life-threatening allergic reaction.***

2. On the next page, there is a medication authorization form to be completed and signed by parent/guardian **and** your child's health care professional to comply with this policy. The health care professional must provide written certification that the student is capable of & trained in the proper administration technique for the medication.

3. All medication must be brought to the health office in the originally labeled pharmacy container. Please ask the pharmacist for a separate properly labeled container for home use. Medications sent in envelopes and plastic bags **cannot** be accepted. **Administration of epinephrine:** medication must be in a pre-filled, single dose auto-injector mechanism containing epinephrine. Please provide two (2) auto-injector kits; one that the student will carry & one to be kept in the Health Office. Use of *Twinject* kit is discouraged and not accepted. Please contact nurse to discuss the reasons for this.

4. The completed form is valid for **one (1) school year**. A new medication from must be completed and filed every school year.

5. Use one (1) form for each medication. The medication form may be duplicated or additional forms are available in the health office.

6. If during the school year, your child's health care professional determines medication is no longer required, he/she must send this information in writing to the school nurse.
   If the dose of the medication is changed, the health care provider must provide this information in writing to the school nurse.

7. Copies of IHA's Medication Policy are available in the Health Office & on the school's website: www.ihanj.com

PLEASE COMPLETE ALL INFORMATION ON NEXT PAGE

SELF-ADMINISTRATION of MEDICATION

Permission for student to use and/or carry metered dose inhaler or other medication for asthma, life-threatening condition/illness or a life-threatening allergic reaction

A. Health Care Professional

Student's Name_____ **DOB** _____ **Grade** ____

Diagnosis(must be p*otentially life-threatening*)_____

Name of Medication_____

Dose(specific) _____**Route(specific)** _____**Frequency(specific)**_____

Side Effects_____

Date Medication Begins_____ **Date Medication Ends**_____

I certify that this student has asthma or another life-threatening condition or life-threatening allergic reaction as listed above and is permitted to self-administer the listed medication. ***The student is capable of and has been instructed in the proper techniques of self-administration and has demonstrated to me competence in this technique.***

Signature of Health Care Professional_____ Date_____

Name of Health Care Professional **(PRINT)**_____

ADDRESS _____

_____

PHONE_____ DATE_____

B. PARENT/GUARDIAN

I have read & understand Immaculate Heart Academy's policy for self-administration of medication for asthma, a life-threatening condition or a life-threatening allergic reaction on the previous page. I authorize my child to self-administer the medication ordered by the health care professional as stated above. This permission includes self-administration of the listed medication during school hours and at times when my child is participating in school related events. I have been informed and understand Immaculate Heart Academy, the nurse, and other school employees or agents shall incur no liability as a result of injury arising from the self-administration of the listed medication. I hereby indemnify and hold harmless the school, the nurse, other school employees or agents, the Archdiocese of Newark, local school district, its Board of Education, Bergen County Department of Health Services and its employees or agents against all claims arising out of the self-administration of the listed medication by the student. I consent to the communication between the nurse or administrators and the prescribing health care professional to ensure the safe administration of the listed medication. I consent to this information being shared on a confidential basis with teachers/chaperones for school sponsored activities.

Signature of Parent/ Guardian_____ **Date**_____

VALID FOR ONE (1) SCHOOL YEAR