Long Hill Township Public Schools
Authorization for Self Administration of Medication

To be completed by the parent/guardian:

Student's name ________________________________ Date of Birth ______

I request that my child be permitted to self medicate himself/herself for asthma or another potentially life threatening illness as authorized by both myself and the student's physician. I understand that the Long Hill Township School District shall incur no liability as a result of any injury arising from my child self administering a prescribed medication. I shall hold harmless the district and its employees against any claims arising from the self administration of medication by my child.

I understand that before my child will be permitted to carry and self administer his/her medication, that I must also provide the school nurse with an additional inhaler, epipen, or other prescribed medication in a *Pre-measured Unit Dose*.

_________ ___________________________ ___________/________________
Date Parent/guardian signature Home phone Work/cell#

To be completed by the physician:

Diagnosis/symptoms for which medication is given: __________________
____

Medication ________________ Dose/route ___________ Time_____________

If the medication is to be used prn, what are the indications for administration? ____

How soon can student receive another dose?__________________________

Significant side effects: ____

Length of time student is to take Rx: ______________________________

I authorize __________________________ to self medicate as outlined above. This child has been instructed on the proper method of self administration.

Physician's stamp _________________________ Phone#__________________

_________________ ______________________________
Date Physician's Signature