Wayne
Township Public Schools

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Request for Self Administration of Medication

Asthma Inhalers _____ Epi Pen_____ Epi Pen Jr._____

STUDENT'S NAME_____SCHOOL_____DATE OF BIRTH_____

To Be Completed by Physician: (Please print)

I am requesting that the above-named student be allowed to self-administer the following medication:

Name of Medication: _____

Diagnosis for which medication is given: _____

Prescribed dosage and time to be taken: _____

If DAILY, at what time? _____

If "WHEN NEEDED", describe indications: _____

How soon can it be repeated? _____

Possible side effects and/or special precautions to be taken: _____

Length of time this medication is prescribed: _____

Conditions under which self-administration will take place:

- ☐ **Independently. Child has been trained and is proficient in self- administering medication.**
- ☐ **Under the supervision of school nurse.**

Medication should be

- ☐ **stored in the nurse's office or designated area.**
- ☐ **in the possession of student.**

_____ _____

Physician's Name (print) **Physician's Signature**

_____ _____

Telephone Number **Date**

To be Completed by Parent: I give my permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician.

The medication is to be provided by me in the original labeled container.
To my knowledge my child is not allergic to this medication.

I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damages which may result to the student, his/her servants and representatives from administration of the medication.

_____

(Parent/Guardian's Signature)

Date_____ School_____

_____

Reviewed by School Physician

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Medication Contract

Student:_____

School:_____

Date:_____

I understand that I will use this medication as directed by my physician. I will be responsible and discreet in using this _____ and should have this

(Name of Medication)

medication readily accessible.

I have been instructed how to self administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container.

I understand that if I do not abide by these regulations I may forfeit my right to carry and self administer this medication.

I understand that this contract is to be renewed annually at the beginning of the school year.

_____

Student **Date**

_____

Parent **Date**