INSTRUCTIONS FOR SELF-ADMINISTRATION OF MEDICATION
This includes permission for student to use/ carry metered dose inhalers or other medications for potentially life threatening condition.

Waldwick Board of Education requires the following conditions be met for a student to self-administer medication during school hours:

1. Written authorization is required from you and your child's health care provider for the self-administration by your child of the listed medication. Self-administration is only permitted for medications treating a diagnosed potentially life threatening condition.

2. The medication authorization form is to be completed and signed by you **and** your child's health care provider. The physician must provide written certification that the student is capable of and trained in the proper administration technique for the medication.

3. All medication must be brought to the health office in a current prescription container, appropriately labeled. Please ask the pharmacist for a separate properly labeled container for home use. Medications sent in envelopes and plastic bags **cannot** be accepted.

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

5. If during the school year, your child's health care provider 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.

6. Use one form for each medication.

EFFECTIVE FOR ONE (1) SCHOOL YEAR

SELF-ADMINISTRATION OF MEDICATION

Permission for student to use and/or carry a metered dose inhaler or other emergency medication for potentially life threatening condition.

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

Diagnosis_____

_____

Name of Medication_____

Dose_____ **Route**_____ **Frequency**_____

Side Effects_____

_____

_____

Date Medication Begins_____ **Date Medication Ends**_____

HEALTH CARE PROVIDER

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

Name of Health Care Provider (PRINT)_____

Signature Of Health Care Provider_____

ADDRESS _____

_____

PHONE_____ **DATE**_____

PARENT/GUARDIAN

I authorize my child to self-administer the listed medication. This permission includes self-administration of the listed medication during school hours and at times when my child is participating in a school related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of the listed medication. I will indemnify and hold harmless the district, school, school nurse and other school employees against all claims arising from the self-administration of the listed medication. I consent to the communication between the school nurse and the prescribing health care provider necessary to ensure the safe administration of the listed medication.

Signature of Parent/ Guardian_____

Date_____

EFFECTIVE FOR ONE (1) SCHOOL YEAR