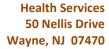


Health Services 50 Nellis Drive Wayne, NJ 07470

Phone: (973) 317-2198 Fax: (973) 317-2159

REQUEST FOR SELF ADMINISTRATION OF MEDICATION Asthma Inhalers Student's Name: Epi Pen Epi Pen Jr. School ____ Date of Birth: 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 Signature Date Reviewed and 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 Medication Prescribed Dosage & Times IF Daily, the time If "When Needed" indicate How soon to be repeated? Side Effects/Precautions Length of Time Prescribed *NOTES Conditions under which self-administration will take place: Medication should be: Independently. Child has been trained and is proficient in stored in the nurse's office or designated area self- administering medication Under the supervision of school nurse in the possession of student Physician's Name (print) Telephone Number Physician's Signature Date





Phone: (973) 317-2198 Fax: (973) 396-8365

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 and should have this
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 re-newed annually at the beginning of the school year.
Student Signature:
Parents Signature: