Wayne Township Public Schools

Health Services
50 Nellis Drive
Wayne, NJ 07470

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

REQUEST FOR SELF ADMINISTRATION OF MEDICATION

	Asthma Inhalers
	Epi Pen
	Epi Pen Jr.

Student's Name: _____

Date of Birth: _____ School _____

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:

- ○ 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) Telephone Number

_____ _____
Physician's Signature Date

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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 medication readily accessible.
(Name of Medication)

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: _____