

HAWORTH PUBLIC SCHOOL
205 Valley Road, Haworth, N.J. 07641
Phone: (201) 384-5526 / Fax: (201) 384-8619

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL
(Inhaler / Epi-Pen / Insulin ONLY)
Physician Prescription

Date: _____ Student's Name/Homeroom: _____

D.O.B.: _____ Weight: _____ School Year: _____

Medication: _____

Dose: _____

Route: _____

Time: _____

Diagnosis/Reason for Medication: _____

Possible Side Effects/Effects of Learning: _____

Any circumstances when medication should not be given: _____

THIS STUDENT MAY CARRY AND SELF-ADMINISTER THIS MEDICATION AND HAS BEEN INSTRUCTED ON HOW TO DO SO.

Physician's Signature: _____

Physician's Name: _____

Address: _____

Phone: _____

The physician must complete this for ANY medication, including "over-the-counter" medications.

PARENTAL AUTHORIZATION

I give permission for my child to carry and self-administer this medication according to my physician's instructions. I also verify that I/we have instructed our child in proper use and self-administration of the above medication and that he/she has demonstrated that he/she is capable of safe and correct self-administration of the above medication. I will notify the school immediately if my child's health status changes or there is a change or cancellation of the medication. 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 relieve the Board and its employees of any and all liability that may result from administration of the medication to my child.

Parent Signature

mydocs/medical form 3.doc

Date