PARENT LETTER RE: SELF ADMINISTRATION OF MEDICATION FOR ASTHMA

The Hopatcong Board of Education will permit the self administration of epinephrine by a student for potentially life threatening illness provided that:

The parents or legal guardian of the student provide the school nurse and principal written authorization for self administration of medication;

The parents or legal guardian of the student provide the school nurse and principal written certification from the healthcare provider that the student has a potentially life threatening illness and has been trained in the proper method of and is competent to self administer the medication;

The Board informs the parents or legal guardians of the student in writing that the school district and its employees or agents shall incur no liability as a result of any injury arising from the self administration of the medication by the student;

The parents or legal guardian of the student sign a statement acknowledging the school district shall incur no liability as a result of any injury arising from the self administration of medication by the student, and the parents or legal guardian shall indemnify and hold harmless the school district, the Board, and its employees or agents from any and all claims arising out of the self administration of medication;

The permission is effective for the school year in which it is granted and must be renewed for each subsequent school year.

For your convenience, a form to be completed by your healthcare provider and you is attached. Should you have any questions, please feel free to contact your child's school nurse.

ASTHMA SELF MEDICATION FORM

TO BE COMPLETED BY HEALTHCARE PROVIDER

STUDENT NAME:_____DATE OF BIRTH_____

I am prescribing the following medication for the above named student and recommend this student to be allowed to self administer the medication. This student would not be able to attend school if the medication is not administered during school hours. He/she is free of contagious disease and physically fit to attend school.

Name of medication:

Diagnosis:

Dosage:

Condition under which medication is to be used:

Length of time medication is to be used:

Potential side effects:

Restrictions this medication may have on student activities:

List other medications student receives that might enhance, alter, or impact the effects of this medication:

This student has been instructed in the proper method of self administration and in my professional opinion is competent to self administer the prescribed medication.

Medication may be kept in student's possession.

Healthcare Provider's Name (Print)_____

Healthcare Provider's Signature/Title_____

Telephone Number_____ Date_____

PAGE TWO TO BE COMPLETED BY PARENT

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN:

I give permission for my child to self administer the medication as prescribed. I understand the Hopatcong Borough School District shall incur no liability as a result of any injury arising from the self administration of medication by my child, and I shall indemnify and hold harmless the school district, the Board, and its employees or agents from any and all claims arising out of the self administration of this medication.

It is further understood that my child will secure this medication in such a manner that is will not be available to other students. My child will report each administration of medication and any side effects to a teacher, coach, or individual in charge.

_____	_____
Parent/Guardian's Name (Print)	Parent/Guardian's Signature
_____	_____
Home Telephone Number	Date
_____	
Work Telephone Number	
_____	_____
Principal's Signature	Nurse's Signature