

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

MR-02

SELF-ADMINISTRATION OF MEDICATION REQUEST FORM

Pupil's Name: _____ School: _____ Grade: _____

Date of Birth: _____ Age: _____ ID#: _____

Self Administration of Medication is permitted in accordance with state statute only for the treatment of asthma or other potentially life-threatening illness and must comply with Board of Education Regulations. All medication requests are effective for one school year only and expire as of July 1st of each year.

SECTION ONE (To be completed by Private Physician/Nurse Practitioner per NJ law)

I certify that it is essential to the health of above named pupil that the following medication be self-administered during school hours as directed. The pupil is physically fit to attend school and is free of contagious disease. The pupil is proficient in self-administering the prescribed medication and has been taught how and when to properly use it.

I hereby request that the above named pupil be allowed to self-administer the following medication as prescribed by me:

Name of Medication: _____ Form of medication: _____

Dosage: _____ Frequency _____ Medication to be taken: PRN _____ Daily _____

Time Medication to be Self-Administered at School: _____

Special Instructions: _____

Diagnosis: _____

Purpose of Medication: _____

Side Effects: _____

Date to Begin: _____ Date to Conclude: _____

Medication should be: _____ in possession of pupil at all times
_____ stored in school health office
_____ in possession of pupil on class trip(s)

Physician's Name (Printed/Typed) _____ Address _____

Physician's Signature _____ Date _____ Telephone Number _____
(Stamp not acceptable)

SECTION TWO (To be completed by parent/guardian)

I give my child permission to self-administer this medication for asthma or other potentially life-threatening illness. My child is capable of taking this medication alone, and has been taught how and when to properly use it. The School District, the Board of Education and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of this medication by my child. I will indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by my child. I will supply the medication in its original container and I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician.

Signature of Parent/Guardian _____ Date _____ Telephone number _____

SECTION THREE (To be completed by staff)

Signature of School Nurse _____ Date Received _____

Signature of Chief Medical Inspector _____ Date _____