NORTHERN HIGHLANDS REGIONAL HIGH SCHOOL

Student Self-Administration of Medication for Asthma or a Potentially Life-Threatening Illness or Allergic Reactions Other Than Epinephrine

Student's Name: _____

Date of Birth: _____

Medication: _____

Physician's Stamp

AUTHORIZATION

PARENT	PHYSICIAN
I request that my son/daughter, as authorized by our physician, be permitted to self-administer the medication(s) indicated below. I understand and agree that: ▪ Only enough medication for the school day or length of a trip is to be carried by the student. The medication must be pre-measured and labeled and carried in the original pharmacy container. ▪ The privilege of self-administration of medication may be revoked if the pupil fails to comply with school policy or this agreement or endangers him/herself or others. ▪ This permission is effective for the current school year only. Medication(s) _____ _____ I acknowledge that the school district shall have no liability for any good faith act or omission consistent with the law which results in any injury arising from the self-administration of medication. I shall indemnify and hold harmless the Board of Education, its officers, employees or agents against any and all claims, suits or causes of action arising out of the self-administration of medication by the my son/daughter. _____ Parent/Guardian Date	Diagnosis of potentially life-threatening illness or allergic reaction (specify) _____ _____ Medications _____ Form (ex. pill)_____ Dose _____ Must the medication be administered during the school day_____ If given daily, what time?_____ _____ How soon may it be repeated?_____ _____ Describe indications_____ _____ Duration of treatment_____ _____ List significant side effects_____ _____ Other information regarding the administration of the medication(s) _____ _____ _____ Is child capable of self-administration of medication? _____ Has the child been instructed on the proper use of the medication?_____ Would the student be able to attend school if the medication was not administered during school hours? _____ _____ Is the student physically fit to attend school if the above listed medication(s) is administered at school? _____ Is the student free of contagious disease? _____ _____ Physician's Signature Date
School Physician's Signature:	