The Titusville Academy
86 River Drive
Titusville, New Jersey 08560

SELF-ADMINISTRATION OF MEDICATION REQUEST FORM

Pupil's Name:_____ Grade: _____ Date of Birth: _____ Age: _____

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: _____stored in school

health office

_____ Physician's Name (Printed/Typed)

_____ Physician's Signature (Stamp not accepted)

_____ Address

_____ Phone Number

_____in possession of Titusville staff member on class trip(s)

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_____

SECTION THREE ***(To be completed by staff)***

Signature of School Nurse_____ Date Received_____ Signature of School

Physician_____ Date_____