Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

SELF-ADMINISTRATION OF MEDICATION FORM

N.J.S.A. 18A: 40-12.3 et seq. (Asthma Inhalers and Epi-pens Only)

School Health Services
Nancy Silverberg
609-584-1800 ext. 229
Email: nsilverberg@thenewgrange.org

Student Name:_____ Date of Birth: _____

PARENTAL REQUEST

I, the parent/guardian of_____, authorize the principal and the school nurse to permit the student to self-administer the prescribed medication as indicated. I understand and agree that the school, school nurse and principal shall incur no liability because of anyinjury arising from the self-administration of medication by the student and I hold harmless the school, school nurse and principal against any claims arising out of the self-administration of medication by the student.

The medication will be brought to school in its original container appropriately labeled by my pharmacy. This request will terminate automatically at the end of the school year.

Signature: _____ Date: _____
Parent/Guardian

PHYSICIAN'S STATEMENT

In order to protect the health of_____it is necessary for him/her to have the following medication during school hours.

Diagnosis: _____

Medication: _____

Dosage: _____

Time to be Administered: _____

Purpose of Medication: _____

Possible Side Effects: _____

Date to Begin/Conclude:
I request that the student be allowed to carry and self-administer the prescribed medications. I certify that the student understands, has received instruction in, and is capable of self-administration.

Licensed Health Care Professional authorizing administration of above medications:

_____ _____ _____
Signature of Physician | Print Physician's Name | Date

_____ _____
Address | Phone

_____ _____ _____
Demonstration Date(s) | School Nurse Signature | Date

AUTHORIZATION DATE: _____ _____
School Nurse