CHERRY HILL SCHOOL DISTRICT

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA OR EPINEPHRINE MEDICATION ONLY BY PUPIL

Date: _____

To: School Nurse

Student: _____

Grade: _____

Academic Year: 20 --- 20 _____

The minor individual named above is my patient. I understand that this patient is a pupil in your school district.

I further understand that Chapter 308 of the Laws of 1993 allows the parent(s) or guardian(s) of a pupil who has asthma or other potentially life-threatening illnesses to authorize self-administration of medication by the pupil so long as the pupil's physician certifies to the school district that the pupil is capable of, and had been instructed in, the proper method of self-administration of medication.

My patient has an illness or condition identified at the end of this form and is required to take the medication also identified at the end of this form.

My patient is capable of, and has been instructed in, the proper method of self-administration of this medication. In the event that the medication which I have prescribed is changed in the future, I will either assure that my patient remains capable of, and has been instructed in the proper method of self-administration of said medication, or will notify the school district that my patient is no longer capable of, or has not been instructed in, the proper method of such self-administration.

I understand that the authorization by my patient's parent(s) or guardian(s) is effective only for the current school year and must be re-authorized by them for each future school year. Any such re-authorization by my patient's parent(s) or guardian(s) for any future school year must be accompanied by anew certification by me.

Nature of Illness or Condition: _____

Type of Medication: _____

Directions: _____

Physician's Signature _____

Physician's Name (print) _____

Phone _____

Date _____

Physician's Stamp

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To: School Nurse

Student: _____

Grade: _____

Academic Year: 20 --- 20 _____

We, the undersigned, are the parent(s) or guardian(s) of the pupil named above.

We have been advised by you that legislation has been enacted allowing parent(s) or guardian(s) of a pupil who has asthma or another potentially life-threatening illness to authorize self-administration of medication by the pupil so long as the pupil's physician certifies to you that the pupil is capable of, and has been instructed in, the proper method of self-administration of medication. We have also been advised by you that if we do give this authorization, the school district and its employees and agents will incur no liability as a result of any injury arising from self-administration of medication by the pupil.

The pupil named above suffers from the illness or condition identified at the end of this form and is required to take the medication also identified on the reverse side of this form.

We authorize the pupil named above to administer the medication to him/herself while the pupil is under your jurisdiction.

We acknowledge that the school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of mediation by the pupil and we agree to indemnify and hold harmless the school district and its employees and agents against any claims arising out the self-administration of medication by the pupil.

We understand that this authorization only applies to this current school year. We have the right to choose whether or not to furnish a new authorization for each future school year.

Signature of Parent or Guardian: _____

Parent's or Guardian's Name (print): _____

Date: _____

Nature of Illness or Condition: _____