HANOVER PARK REGIONAL HIGH SCHOOL DISTRICT

____ Hanover Park High School ____ Whippany Park High School

Physician's Order for Administration of Medicine at School

Physician's prescribing medication that must be administered to pupils during school hours or at school activities for periods of more than ten school days or as needed throughout the school year are requested to complete this information form. The form must be filed with the school nurse prior to the start of medication at school. This order is valid only for the school year it is issued.

I am treating the following student and have prescribed medication which must be administered during school hours:

Student_____ Date of Birth_____

Name of medication_____

Reason for medication_____

Form of medication/treatment

__Tablet/capsule ___ Liquid ___ Inhaler ___ Injection ___ Nebulizer ____ Other _____

Schedule and Dosage to be given at school_____

Length of Time for Medication

State date of medication_____

Stop date of medication_____

OR

___ Medication is to be administered for episodic/emergency events only.

Restrictions and/or Important Side Effects

____ None anticipated

____ The following restrictions and/or critical side effects must be noted:

_____

(Please also complete the reverse side)

Special storage requirements _____ None _____ Refrigerate

Other _____

Administration of the medication shall be performed by:

_____ The school nurse/school district designee

OR

_____ This is a life-threatening situation and the pupil should be permitted to self-administer the medication.

Note: All medication will be administered by the school nurse. In the case of life-threatening illness that may require an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life, the physician must also complete a. and b. below to authorize self-medication by the pupil.

a. I certify that this pupil is being treated for the following life-threatening illness:

b. I authorize this pupil to self-administer the above-prescribed medication. I further certify that this pupil is capable of, and has been instructed in, the proper method of self-administration of the above-prescribed medication.

Please indicate if you have attached additional information to this form. _____ Yes _____ No

Date_____ Physician's Signature_____

Physician's Name_____

Address_____

_____

Telephone_____

HPRHSD 3/09

Date Received:

Approved:

HANOVER PARK REGIONAL HIGH SCHOOL DISTRICT

___ Hanover Park High School ___ Whippany Park High School

Parent/Guardian's Request For Administration of Medication at School

This form is to be completed by parents/guardians of pupils of the Hanover Park Regional High School in situations were the pupil's physician has prescribed medication that must be administered during school hours or at school activities for periods of more than ten school days or needed

I/We are the parents/guardians of the following student whose physic ian has prescribe medication which must be administered during the school hours:

Student _____ Date of birth _____

Name of medication _____

Reason for medication _____

This medication will be administered by:

___ The school nurse /school district designee

OR

___ This is a documented life-threatening condition and the pupil should be permitted to self-administer this medication. (The reverse side of this form is also completed.)

[Life threatening condition is defined as a condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life. In accordance with N.J. Law, pupils may self-administer medication in such situations only when authorized by the parents/guardians and the pupil's physicia n.]

I/We request that the school authorize administration of medication during school hours in accordance with Board of Education Policy JHCD. I/We and our child agree I/we/he/she shall hold harmless the Board of Education and its employees or agents for the administration of this medication during school hours.

_____ _____

Parent Name Signature

_____ _____

Parent Name Signature

_____ _____

Pupil Name Signature

Date: _____

Please see reverse side of this form.

Complete this additional side of the form ONLY if you are requesting permission for your pupil to self-administer medication for a potentially life-threatening illness.

I/We are the parents/guardians of the following pupil and request permission under the provisions of New Jersey Statutes 18A:40-12.3 for our pupil to self-administer medication for a potentially life-threatening illness.

Student _____ Date of birth _____

Name of Medication _____

I/We certify that our pupil suffers from the following life-threatening illness:

_____

I/We authorize our pupil to self-administer the stated medication as required. I/We shall obtain and submit the required certification of the pupil's physician stating that the pupil does require self-medication due to a potentially life-threatening illness and that he/she is capable of self-administration and has been instructed in the proper administration methods.

I/We have been informed by the Board of Education that the Hanover Park Regional High School District, the Board of Education, its employees and/or agents shall incur no liability as a result of any injury arising from the self-administration of the medication by our pupil. I/We acknowledge that the Hanover Park Regional High School District, the Board of Education, its employees and/or agents shall incur no liability as a result of any injury arising from the self- administration of this medication by our pupil and shall indemnify and hold harmless the District, the Board of Education, its employees and/or agents against any and all claims that may arise our of the self-administration of medication by our pupil.

I/We understand that this approval is granted for the current school year and must be renewed for each subsequent school year.

_____ _____
Parent Name Signature

_____ _____
Parent Name Signature

_____ _____
Pupil Name Signature

Date: _____

Date Received:
Approved:

HPRHSD 8/95