Hopewell Valley Regional School District
Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

AUTHORIZATION FOR EMERGENCY MEDICATION TO BE TAKEN AT SCHOOL

PART I - TO BE COMPLETED BY STUDENT'S PARENT / GUARDIAN

Child's Last Name | First | Middle | Gender | Birth date (month/day/year)

Physician's name | Physician's telephone

Physician's address

I request that my child be assisted by authorized personnel in taking the emergency medication prescribed below or be permitted to self-medicate as authorized by me and my physician. I hereby release the Board of Education and its employees of all liability for injury arising from self-administration. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications.

Parent / Guardian Signature | Date

Home telephone | Emergency telephone

PART II – TO BE COMPLETED BY THE PHYSICIAN

_____ is under my care for _____, which is a potentially life-threatening condition. The following medication has been prescribed for use in an emergency situation:

Name of medication: _____

Form dosage: _____

Indications for use of medication: _____

How soon can it be repeated? _____

Significant side effects: _____

Other instructions: _____

Length of time order is valid: _____

Do you authorize the child to self-medicate? _____

I certify that the above student is capable of, and has been instructed in, the proper method of self-administration of his/her emergency medication.

Signature of Physician | Date