

Manchester Township School District

One Medication per form

Form valid for one school year _____

Dear Parent/Guardian:

The administration of medication to students in our schools must follow certain rules.

1. A written physician's note as well as a parental request is required for any medication to be given in school. This applies to prescription **and** over-the-counter drugs.
2. Prescription drugs must be in the **original** container with the date, MD and student's name, directions for use, & prescription number. Over-the-counter drugs must also be in the original container.
3. All medications are to be held in the Health Office, not carried. (See Self-Medication exception).
4. Self-medication of inhalers and Epi-Pens are only permitted with Physician and parental signatures in the appropriate space on this form.
5. NJSA 18A:40-12.8 regulates and requires an asthma treatment plan for pupils authorized to use asthma medication. **The Asthma Action Plan** meets the NJ Law 18A:40-12.8 and can be found at www.pacnj.org

Parent/Guardian

Name of Student _____ Grade _____
Parent Signature _____ Date _____

TREATING PHYSICIAN

Physician's Name _____ Phone _____
Diagnosis _____ Name of Medication _____
Dose & Time to give _____
Side Effects _____
Physician's Signature _____ Date _____

Valid office stamp must accompany Physician's signature.

SELF MEDICATION (EPI- PEN OR INHALER ONLY)

I acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that the parent/guardian shall indemnify and hold harmless, the district, it's employees, or agents against any claims arising out of the self-administration of medication by the pupil.

Signature of Parent/Guardian _____ Date _____

_____ (Name of student) has received instruction in the self-administration of the prescribed medication for the illness/condition described above and is capable of giving to him/herself.

Physician Signature _____ Date _____