BYRAM TOWNSHIP SCHOOLS
REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Student's Name_____D.O.B._____School_____Date_____

Parent/Guardian Name_____Tel.# Work_____
Home_____

Physician's Authorization: (please print)

I am recommending that the above-named student be allowed to self-administer the following medication:

Identification of Chronic Medical Problem:_____

Name and purpose of medication:_____

Prescribed dosage to be taken:_____

Length of time medication must be taken:_____

Possible side effects and/or special precautions to be taken:_____

_____

Conditions under which self-administration will take place:

1. Independently. Child must have had training and be proficient in self-administering medication.

   Trainer's name_____Date of Training_____

2. Medication will be in the possession of student. As part of the above training, the student has been instructed regarding the responsibility for caring for his/her medication.

_____ _____
Physician's Name (Print) Physician's Signature

_____ _____
Telephone Number Date

Parental Authorization: I give my permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or self-medication is no longer directed by the physician.

I understand and I acknowledge that the Byram Township School district and it's employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child.

I indemnify and hold harmless the Byram Township School district and its employees or agents against any claims arising out of the self-administration of medication by my child.

I understand also, that the permission of self-administration of medication by my child is effective only for the school year in which it was granted and that renewal of this permission will require application during each of the subsequent school years when the self-medication is needed.

I understand that the privilege of self-medication may be withheld if the student fails to comply with this policy and the conditions of this agreement.

_____
Parent Signature

TO BE COMPLETED BY BYRAM TOWNSHIP SCHOOLS' MEDICAL EXAMINER

I have reviewed this request for self-administration of emergent medication and recommend that it

1. ☐ be approved
2. ☐ not be approved

If number 2 is checked, please state reason: _____

_____

_____

_____ _____
Signature of Medical Director Date

If approved by Medical Director -

_____ _____
Chief School Administrator's Signature Date

If approved by Chief School Administrator -

_____ _____
Principal's Signature Date

_____ _____
Nurse's Signature Date

Classroom teacher/teachers or other school personnel has/have been notified on

_____ _____
Date Nurse's Signature

*Copies of completed form must be forwarded to the Chief School Administrator, Principal and Student Health File.