GLOUCESTER CO. SPECIAL SERVICES SCHOOL DISTRICT
NONPUBLIC NURSING PROGRAM
1340 Tanyard Road
Sewell, NJ 08080
(856) 468-6530 x1045

ST. MICHAEL THE ARCHANGEL SCHOOL
51 West North Street
Clayton, NJ 08312-1220
(856) 881-0067
Fax # (856) 881-4064

PARENT/GUARDIAN PERMISSION FOR MINOR STUDENT TO SELF-ADMINISTER MEDICATION

THIS ORDER MUST BE RETURNED IN ITS ORIGINAL FORM. FAXES AND COPIES WILL NOT BE ACCEPTED.

I, the parent/guardian of _____ authorize my child, a pupil
(Name of Student)
at _____ School to self-administer medication (epinephrine and/or inhaler
(Name of School)
and/or pancreatic enzymes) prescribed by our physician as described below for a life-threatening condition.

I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. **I further understand that neither the GCSSSD Board of Education, nor any district employee shall be responsible for any liability as a result of any injury arising from the self-administration of this medication by my child.** I understand that if my child misuses or exceeds the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication.

_____ _____
Parent/Guardian Signature **Date**

PHYSICIAN'S OR NURSE PRACTITIONER'S AUTHORIZATION/ASSURANCE STATEMENT FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION

I certify that _____ is under my care for _____, a life-threatening condition. I am recommending that the above named student be permitted to self-administer medication (epinephrine and/or inhaler and/or pancreatic enzymes). In the case of epinephrine, the student named has a documented history of anaphylaxis. He/she is capable of, and has been instructed by me in the proper method of self-administration of the following medication (use a separate sheet for each medication):

Name of medication: _____

In the case of anaphylaxis, symptoms of previous reaction: _____

Chronic medical problems: _____

Prescribed dosage and schedule: _____

Possible side effects and/or special precautions: _____

_____ _____
Prescribing Physician's/Nurse Practitioner's Signature (Must be original – NO STAMPS PLEASE) Date

_____ _____
TELEPHONE #

_____
PLEASE PRINT NAME AND ADDRESS OF PRESCRIBING PHYSICIAN

NEITHER THE GLOUCESTER COUNTY SPECIAL SERVICES SCHOOL DISTRICT BOARD OF EDUCATION NOR ANY DISTRICT EMPLOYEE SHALL BE RESPONSIBLE FOR ANY LIABILITY AS A RESULT OF ANY INJURY TO THE ABOVE NAMED STUDENT, ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION OR ANY MISUSE OF THE MEDICATION.