ATLANTIC COUNTY INSTITUTE OF TECHNOLOGY
HEALTH OFFICE
5080 ATLANTIC AVENUE
MAYS LANDING, NJ 08330
PHONE:(609) 625-2249 x1231 FAX: (609) 625-8622

Permission to Administer Medication

Dear Parent(s)/Guardians and Doctor:

It is preferred that any medication, whether prescription or nonprescription, be given before or after school hours whenever possible. However, if it is essential that the student receive medication during school hours we will need you to provide the following information. Please note that there is a section to be completed by the physician on the front and a section to be completed by the parent / guardian on the reverse side. **This form is valid for the current school year only.**

Thank you for your cooperation.

To be completed by Doctor / Physician

Child's Name: ______________________ Date of Birth: ______________________

Medical Diagnosis: ______________________

Name of Medication: ______________________

Dosage: ______________________ Route: ______________________

List indication for use: ______________________

Side Effects: ______________________

Duration of Order: ______________________

List of medications child is on which may enhance, alter, or impact this medication:

____

____

This student may participate in physical education? [ ] Y [ ] N

If no, please list any limitations or comments:

____

____

Physician's Phone Number: ______________________

____

Physician Name　　Physician Signature　　Date

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Permission to Administer Medication

Dear Parent(s)/Guardians and Doctor:

Please complete the sections below to allow your child to receive medication(s) while they are in school. Please note that the lower section is for self administration of medication for asthma or potentially life threatening illness ONLY.

Thank you for your cooperation.

To be completed by Parent / Guardian

Administration of Medication by the School Nurse

I request and grant permission for the school nurse to administer medications to my child, ____________________________ as prescribed by his/her physician as indicated on the reverse side of this form and as per the policy of the Atlantic County Vocational School District, Board of Education, and State law. I understand that any medication is to be brought to the school by myself in the original prescription bottle/box labeled properly by the physician or pharmacist.

Parent/Guardian Name	Parent/Guardian Signature	Date

Pupil Self-Administration of Medication

The Board of Education shall permit self administration for asthma or other potentially life threatening illnesses by pupils, both on school premises during regular school hours and off site, or after regular school hours when the pupil is participating in field trips or extracurricular activities, and the school nurse and his/her designee is not present. Life threatening illness means an illness or condition that requires immediate response to specific symptoms or sequel that may indicate the potential loss of life. (i.e. adrenaline injection in response to anaphylaxis. Example: Epi-Pen)

My child, ____________________________ has permission to administer his/her own medication ________________________ for asthma or other potentially life threatening illnesses both on school premises during regular school hours and off site, or after regular school hours when they are participating in field trips or extracurricular activities. I acknowledge that the Atlantic County Vocational School District shall incur no liability as a result of any injury arising from his/her self-administration of medication by my child. I indemnify and hold harmless the district and it's employees or agents against any claims arising out of self-administration of medication by my child.

Parent/Guardian Name	Parent/Guardian Signature	Date

****** Attention those with Asthma ******

It is required by the State of NJ, that any student who has Asthma needs an Asthma Action Plan. Please have your Physician complete one and attach it to this sheet. They can be obtained at your Physician's office or from http://pacnj.org

Suggestions:
Carry one inhaler, and if possible please bring an extra one to the nurse's office in case you forget to carry yours.

Parent/Guardian Name	Parent/Guardian Signature	Date