OLD TAPPAN PUBLIC SCHOOL DISTRICT

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL
(Inhaler/Epi-Pen/Insulin ONLY)

PRESCRIBER'S AUTHORIZATION

Name of student_____Date of birth_____Grade_____

Medication Name_____

Medication Dose_____Medication route_____

Time/frequency of administration_____

Condition for which medication is prescribed_____

If prn, for what symptoms_____If prn, frequency_____

Possible side effects_____

Medication order for time period of _____to _____

The prescriber certifies that the student is physically fit to attend school and is free of contagious disease.
The prescriber certifies that, due to a life-threatening condition, the student would not be able to attend school unless medication can be taken during school hours.
The prescriber certifies that THIS STUDENT IS CAPABLE OF AND MAY CARRY AND SELF-ADMINISTER THIS MEDICATION AND HAS BEEN INSTRUCTED ON HOW TO PROPERLY DO SO.

Prescriber's name/title_____
Telephone_____
Address_____
_____

Prescriber's signature_____Date_____

PARENT AUTHORIZATION

I give permission for my child to carry and self-administer the above medication in school and during school-sponsored functions. I acknowledge that the school district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I indemnify and hold harmless the school district, the Board, and its employees or Agents against any claims arising out of the self-administration of medication by the student named above. I verify that my child is capable of safe and correct self-administration of said medication. I certify that I have the legal authority to make medical decisions for the above named student. I understand this permission must be renewed each school year. I understand that I am responsible for the medication carried/administered by my child.

Parent signature_____Date_____

SCHOOL PRINCIPAL APPROVAL_____Date_____

SCHOOL PHYSICIAN APPROVAL_____Date_____