Attachment A

WASHINGTON TOWNSHIP PUBLIC SCHOOLS

REQUEST FOR PUPIL MEDICATION TO BE TAKEN AT SCHOOL

The administration of medication to or by any pupil will be permitted only when failure to take such medication would jeopardize the health of the pupil or the pupil would not be able to attend or benefit from his/her educational program. Medication includes all prescriptions and patent medications (over the counter). Washington Township Public Schools requires both physician and parent permission to administer all medication, including patent (over the counter) medication.

Note to Parent/Guardian: All medication(s) whether patent or prescribed shall be provided to the school nurse by the parent/guardian in the original container. In the case of prescription medication, the original container must have affixed the current prescription labeling as applied by the pharmacy.

Authorizations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the school's Health Office before any medication can be administered.

SECTION A: Parent Request and Consent (To be completed by *Parent/Legal Guardian*)

PLEASE PRINT:

Pupil's Name: _____ School: _____

Parent's/Guardian's Name: _____

Address: _____

Home Phone #: _____ Parent's/Guardian's Work Phone: _____

PARENT'S CONSENT AND SIGNATURE

I, _____ (Name of Parent/Legal Guardian), request that my child, _____, be assisted in taking the medication(s) described above at school, as authorized by me and my physician.

_____ _____

Parent/Guardian Signature Date

See next page for information to be completed by physician

SECTION B: Physician's Certification (To be completed by the *Physician*)

Physician: _____

Diagnosis for which medication is given: _____

Name of medicine: _____

Form (oral, injection): _____

Dose: _____

If given daily, at what time? _____

If given when needed, describe indications. _____

How soon can it be repeated? _____

Are there significant side effects? _____

Length of time this treatment will continue? _____

Other significant information: _____

I certify that the above statements are true and that the pupil is physically fit to attend school and is free from contagious disease. He (she) would not be able to attend school if the medication is not administered during school hours.

Physician Signature _____ Date _____

Affix physician's official stamp here:

SECTION C: Nurse's Review (To be completed by the *School Nurse)*

Pupil's Name: _____

Check one:

_____ The request for administration of the above-referenced medication by the school nurse is approved.

_____ The request for administration of the above-referenced medication by the school nurse is denied.

Reason for Denial: _____

_____

_____

_____

The parent/legal guardian has the right to appeal the denial to the Principal.

_____ _____

Signature of Nurse Date

Section D: Controlled Substance Record (To be completed for all controlled medications)

Date of Receipt	Quantity Received	Parent's Signature	Nurse's Signature

ATTACHMENT B

WASHINGTON TOWNSHIP PUBLIC SCHOOLS
Department of Student Services

CONSENT FORM AND NOTICE FOR ADMINISTRATION OF EPINEPHRINE VIA EPI-PEN
(To be completed in conjunction with Attachment A)

Pupil's Name: _____ **School:** _____ **School Year:** _____

SECTION A: Parent's Consent and Acknowledgements

I (we), _____ , (parent's/legal guardian's name) hereby consent to the emergency administration of epinephrine via a pre-filled auto-injector mechanism containing epinephrine to our child, _____, (child's name) by the certified school nurse or designee and/or additional staff members who have volunteered and have been trained as delegates for the administration of epinephrine.

I (we) have provided the school with written authorization for the administration of epinephrine with written orders from the physician or an advanced practice nurse that our child requires the administration of epinephrine for anaphylaxis.

I (we) understand that if the procedures as outlined in Board of Education Policy 5330 and the New Jersey Administrative Code and Title 18A (copies of which have been provided to me (us)) are followed, the Washington Township Board of Education and its employees and agents shall have no liability as a result of any injury arising from the administration of epinephrine via epi-pen to my child.

I (we) further agree to indemnify and hold harmless the Washington Township Board of Education and its employees and agents against any claims arising out of the administration of epinephrine via epi-pen to our child.

Signature of Parent(s)/Legal Guardian:

_____ _____

Mother/Legal Guardian Date

_____ _____

Father/Legal Guardian Date

Name, Address, and Phone Number of Child's Physician:

_____

_____

Phone Street Address City, State, Zip

WASHINGTON TOWNSHIP PUBLIC SCHOOLS

Authorization Form for Pupil Self-Administration of Medication(s) and Other Potentially Life-Threatening Illness(es) and/or Life-Threatening Allergic Reactions(s)

Permission for self-administration of medication of a pupil with asthma, other potentially life-threatening illness, or a life-threatening allergic reaction may be granted under the following conditions:

1. Signed parental authorization for the self-administration of medication.
2. The parent(s) or legal guardian(s) of the pupil must also provide the Board with a signed written certification from the physician of the pupil that the pupil has asthma or another potentially life threatening illness or is subject to a life-threatening allergic reaction and is capable of, and has been instructed in, the proper method of self-administration of medication. (Attachment C.1)
3. A statement the medication must be administered during the school day or the pupil would not be able to attend school.
4. The parent(s) or legal guardian(s) of the pupil have signed a statement acknowledging that the school 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(s) or legal guardian(s) shall 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 pupil.
5. The parent's and/or legal guardian's written authorization and the home physician's written certification shall be reviewed by the school nurse and the school physician. The school nurse and the school physician must agree the pupil is capable of self-administration of the medication. If it is determined the pupil may self-administer medication in accordance with the request, the request will be signed by the principal and a copy given to the school nurse and the pupil's parent(s) or legal guardian(s). If it is determined that the request for self-administration will be denied, the school nurse will notify the Principal and then inform the parent(s) or legal guardian(s) of the reason for a denied request; a denied request may be appealed to the Principal.
6. Permission to self-administer one medication shall not be construed as permission to self-administer other medications; and
7. Permission shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year upon fulfillment of the requirements in 1. through 4. above.
8. The student's ability to self-administer a particular medication shall be documented in his/her Individualized Healthcare Plan. The Individualized Healthcare Plan shall also indicate how the medication will be pre-measured, labeled, and carried to ensure that the student carries only the quantity necessary for a prescribed time.

Authorization Form for Pupil Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

Authorizations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the school's Health Office before any medication can be administered. Permission shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year upon fulfillment of the requirements in 1. through 5. listed on Attachment C.

SECTION A: Parent's/Legal Guardian's Consent and Acknowledgements
(To be completed by the student's *Parent/Legal Guardian*)

I (we), _____, (name of parent/legal guardian) authorize my(our) child, _____ _____, (child's name) to self-administer prescribed medication to treat his/her medical condition which is deemed potentially life threatening for the _____ to _____ school year. The specific medication(s) are (please list specific medication(s) _____ _____, as indicated on the attached certification from my child's physician, Dr._____ _____ (name of physician). It is also understood that permission for our child to self-administer this (above listed) medication shall not be construed as permission to self-administer other medications. I/we understand that permission shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year upon fulfillment of necessary requirements.

I (we) understand that the Washington Township Board of Education and its employees and agents shall incur no liability as a result of any injury arising from our child's self-administration of medication and that we (the parents/legal guardians) shall indemnify and hold harmless the school district, the Board, and its employees or agents from any and all claims arising through the self-administration of this medication by our child.

Signature of Parent(s)/Legal Guardian

_____ _____
Mother/Legal Guardian Date

_____ _____
Father/Legal Guardian Date

Name, Address, and Phone Number of Child's Physician: _____

_____

_____
Phone Street Address City, State, Zip

WASHINGTON TOWNSHIP PUBLIC SCHOOLS **Attachment C.1-B (Cont.)**

Authorization Form for Pupil Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

SECTION B: Physician's Certification (To be completed by *pupil's* physician)

Pupil's Name: _____ Age: _____ Grade: _____ School: _____

Name of Medication: _____

Dosage: _____ Frequency: _____ Oral: _____ Parenteral: _____

Possible Side Effects:

_____

Date When Medication Will Be Discontinued: _____

Specific Nature of Pupil's Illness/Condition:

_____

It is my understanding that the School Nurses of Washington Township Public Schools charged with the administration of medication may rely upon my directions as contained in this document. Pupils with asthma or other potentially life threatening illnesses deemed sufficiently responsible by their physician and parent shall be permitted to have in their possession prescribed medication for the treatment and prevention of life-threatening illnesses or condition during school hours, athletic events and practices and field trips. I hereby deem the above named pupil to be sufficiently capable having been instructed in the proper method of self-administration of medication pursuant to Chapter 308 of the laws of 1993, to carry his/her prescribed medication of the medication listed above. I further certify that I am the physician who prescribed the medication and that the pupil named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

I certify that the above statements are true and that the pupil is physically fit to attend school and is free from contagious disease. He (she) would not be able to attend school if the medication is not administered during school hours.

_____ _____

Physician's Name (Please Print/Type) Physician's Signature

Address: _____

Date: _____ Telephone: _____

Affix physician's official stamp here:

Washington Township Public Schools **Attachment C.1-C**

Authorization Form for Pupil Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

SECTION C: SCHOOL OFFICIAL'S REVIEW AND CONCURRENCE
(This section is to be completed by the *School Nurse and the School Physician*.)

SCHOOL NURSE AND SCHOOL PHYSICIAN

I have reviewed the parent's/legal guardian's written authorization and the pupil's physician's written certification and agree that the above-referenced pupil is capable of self-administration of the medication prescribed by the pupil's physician.

School Nurse's Name (Print)	School Physician's Name (Print)
School Nurse's Signature	School Physician's Signature
Date	Date

Affix school physician's official stamp here:

BUILDING PRINCIPAL

I have reviewed this request for self-administration with the school nurse and school physician. The school nurse and school physician agree that this pupil, _____,
is capable of self-administration of the medication prescribed by the pupil's physician. It is therefore determined that the pupil may self-administer this medication in accordance with the parent's/legal guardian's request.

Principal/Administrative Designee Signature	Date