PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

SELF-ADMINISTRATION OF MEDICATION
(ALLERGIC REACTION/ASTHMA/INSULIN)

Dear Parent/Guardian:

Please have your child's physician complete the form as it appears and return it to the school nurse as soon as possible.

1. Pupil's name _____
2. Diagnosis _____
3. Name of medication _____

   PLEASE NOTE: An order for epinephrine may be administered by a non-medical trained delegate who is authorized to administer epinephrine ONLY. As such, antihistamines or other medications cannot be given by the delegate. Please take this into consideration when writing your order. If you have any questions in this regard, please call the school nurse. Thank you.
4. Dosage _____
5. Route _____
6. Time to be administered _____
7. Special instruction _____
8. Side effects _____

I certify that the above-mentioned child is capable of, and has been instructed in, the proper method of self-administration of the medication as is indicated above.

_____ _____
Physician's Signature Date

Please print, type or stamp

Physician's Name: _____

Address: _____

Telephone: _____

License No.: _____

I acknowledge that the Parsippany-Troy Hills School District shall incur no liability as a result of any injury arising from my child holding in his physical possession and the self-administration of the above mentioned medication, and I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the holding and self-administration of this medication.

This permission is effective for the current school year only and will be reviewed each subsequent school year if the medication needs to be continued.

_____ _____
Parent's Signature Date

SN# 4
3/16