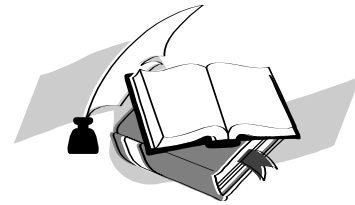


# Dunellen Public Schools

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## **SELF-ADMINISTRATION OF LIFE THREATENING MEDICATIONS**

N.J.S.A. Title 18A:40-12.3 directs that students may be permitted to self-administer medications for asthma or other potentially life-threatening illnesses provided proper procedures are followed. This form must be individually completed for **all prescribed medications**.

**The following section is to be completed by the PARENT/GUARDIAN:**

\_\_\_\_\_  
**Student's Name**

\_\_\_\_\_  
**Grade**

I request that my child be ALLOWED to carry the following medication

\_\_\_\_\_ for self-administration. in school pursuant to  
N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed on this form for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

**RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY  
AND MUST BE RENEWED ANNUALLY**

**The following section is to be completed by the PHYSICIAN:**

Potential life-threatening Diagnosis for which medication is given:

\_\_\_\_\_

Name of medication:

\_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency:

\_\_\_\_\_

If medicine is be given "WHEN NEEDED", describe indications/symptoms:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How soon can the medicine be repeated?

\_\_\_\_\_

List significant side effects:

\_\_\_\_\_

Any restrictions or limitations:

\_\_\_\_\_

Date prescribed: \_\_\_\_\_

Date to be discontinued:

\_\_\_\_\_

I verify that the child above requires this medication and

- a. This student has been instructed in and is capable of proper method of self-administration of the medication prescribed above.
- b. This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.
- c. The student's medication, if ingested by someone other than the student will not cause severe illness or death.

\_\_\_\_\_

Physician's Name

Address

Telephone no.

Physician's Signature

Date

Approved By School Nurse: \_\_\_\_\_

Signature

Date

Approved By School MD: \_\_\_\_\_

Signature

Date