HENRY P. BECTON REGIONAL HIGH SCHOOL

120 Paterson Ave., East Rutherford, NJ 07073 Phone: 201-935-3007 Fax: 201-935-5639

Self-Administration/Emergency Medication Contract (e.g., Epipen, inhaler, insulin)

Student Name:_____DOB:_____Grade:_____

TO BE COMPLETED BY PARENT/GUARDIAN: I give permission for my student (CHECK APPROPRIATE LINE):

_____to self-administer the prescribed medication(s) as directed and permitted by law

_____to have the medication(s) administered by the nurse

IMPORTANT: Benadryl can ONLY be self-administered by a student IF it is prescribed to be given simultaneously with an Epipen, with NO observation time period.

I understand that the prescribed medication(s) must be supplied by the parent/guardian and brought to school in the original labeled pharmacy container. I will notify the school nurse if there are any changes in the prescribed orders of such medication(s). I also understand that:

1. If so ordered by a physician, the above student can self-administer such medications as are permitted by law, both on school premises and off-site during regular school hours, or after regular hours when my student is participating on field trips or in school-sponsored extracurricular activities.

2. I must provide the Carlstadt-East Rutherford Regional Board of Education with a written order from my student's healthcare provider that my student has a potentially life-threatening condition and is capable of and has been instructed in the proper method of self-administration of the prescribed medication.

3. That the district shall incur no liability as a result of any injury as it concerns the use of this prescribed medication(s).

4. That I will indemnify and hold harmless the Carlstadt-East Rutherford Regional Board of Education and its employees or agents any claims as it concerns the use of this medication.

5. This permission is effective for the current school year ***only*** and ***must be renewed each subsequent school year***.

Authorization for release of information:

_____I give my permission for the release/exchange of pertinent information between the school nurse and the licensed prescriber's office by telephone, mail, or electronic exchange regarding all of the medical/medication information described on this form concerning my child.

_____I give permission to share this information with appropriate staff that are involved in the education of my student.

Parent/Guardian Signature_____Date_____

PLEASE COMPLETE BOTH SIDES OF FORM

PLEASE COMPLETE BOTH SIDES OF FORM

TO BE COMPLETED IF STUDENT IS TO SELF-ADMINISTER

I understand that I will use this medication(s) as directed by my healthcare provider. I will be responsible in using _____ and should have this medication readily accessible. I have been instructed how to self-administer this medication, and understand the side effects of improper use.

Student
Signature_____Date_____