Medication Form – **2018 - 2019 School Year**
(Prescription/Asthma/Allergy/Emergency Medication)

THIS FORM IS EFFECTIVE FOR **ONE SCHOOL YEAR** AND MUST BE RENEWED ANNUALLY.

Student Name_____ DOB_____ Grade_____

Allergy to _____

Name/Purpose of Medication _____

Dosage_____ Time(s) to be administered _____

Length of time medication must be taken _____

Possible side effects

_____

_____

_____

This medication is _____ over the counter _____ Prescription medication

This student has permission to carry a _____ prescription inhaler and /or _____

Epinephrine injection kit due to the nature of his/her medical condition.

_____ _____

Parent/Guardian Signature Date Physician's Signature Date

IN THE EVENT OF AN ANAPHYLACTIC REACTION, THE FOLLOWING DIRECTIVES WILL BE CARRIED OUT:

1. Administer _____
Medication/Dose/Route

2. Call Rescue Squad _____

3. Call: Mother _____ Father _____ Emergency Contact_____

4. Call: Dr. _____ at _____

IF THE NURSE IS NOT ON THE PREMISES, NON-MEDICALLY TRAINED SCHOOL PERSONNEL WILL ADMINISTER EPINEPHRINE INJECTION.

_____

_____

As per parent/guardian of the above names student, I understand that if the procedures specified in N.J.S.A. 18A:40-12.5 are followed, the nurse, district, non-public school and/or service provider shall have no liability as a result of injury arising from the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to the student and shall indemnify and hold harmless the nurse, district, non-public school, service provider and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to the student.

_____ _____

Parent/Guardian Signature Date