UPPER TOWNSHIP SCHOOL DISTRICT
MEDICATION SELF ADMINISTRATION FORM

Due to medical conditions such as asthma or anaphylactic reactions, your child may be a candidate for self-medication in school. In order to do so, we request that your physician and yourself complete this form. This must be completed on an annual basis to ensure a current medical status for your child. If at any time you wish to change or update this form, please contact the school nurse.

PARENT PROVIDED INFORMATION

Child's name _____Grade _____ Date _____

Parent(s)Guardian(s)name _____

Home phone _____ Cell phone_____ Work phone _____

Doctor's name _____ Phone number _____

Medication to be self-administered _____ Dosage _____ Frequency _____

I am aware that the school nurse shall document each instance of the administration of medication to a pupil. Pupils self-administering medication shall report each incident to a teacher, coach or other individual designated by the school district to be in charge of the pupil during school activities. Such individuals shall record and report such incidents to the school nurse within 24 hours of the self-administration. The school nurse shall preserve records and documentation regarding the self-administration in the appropriate file. The school nurse will advise teachers as to any child's use of medication as needed.

I also acknowledge that the school district shall incur no liability as a result of any injury arising from the self administration of medication by my child and I indemnify and hold harmless the school district, the Board, and its employees or agents from any and all claims arising out of the self administration of medication. I acknowledge that my child may not provide medication to another student. To do so may result in disciplinary action.

My son/daughter would not be able to attend school if medication is not administer as needed per doctors orders during the school day. Yes____ No ____
Additional information _____

If your child is asthmatic, please complete the following:

1. Is your child using other prescribed medication for asthma at home on a regular basis? Yes____ No____

   Name of medication _____.
2. When your child experiences and asthma attack, what symptoms does he/she display?

   _____
3. What is most likely to cause your child to have an attack? Please check below as applicable.

   Exercise_____Allegens_____Infection_____Weather_____ Other_____
4. What usually helps if an attack occurs?_____
5. Does your child us use a peak flow meter? Yes_____No_____ Normal range?_____

Parent/Guardian signature _____

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PHYSICIAN PROVIDED INFORMATION

Medications to be given in school:

Name & dosage_____Frequency_____

Possible side effects_____

If inhaled medication has been ordered, can child carry and use inhaler by him/herself? Yes_____ No_____

Has child been instructed in the proper use of the inhaler, or other medication? Yes_____ No_____

If child does not respond to medication, what action should school personnel take?

_____

_____

Does child have any physical education restrictions? Yes_____ No_____

List specifics_____

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S NAME PRINTED _____

DATE _____

Please complete and return to :
Upper Township Middle School
C/o VeAnn Sackett, RN, CSN
525 Perry Road
Petersburg, NJ 08270

Or:
Upper Township Elementary School
C/o Mrs. Arlene Speed, RN
50 Old Tuckahoe Road
Marmora, NJ 08223