MANCHESTER REGIONAL HIGH SCHOOL
Health Office
70 Church Street
Haledon, NJ 07508
973-389-2853 Fax: 973-956-8805

Date: ___________________________________
Grade: __________________________________
School Calendar Year: ______________________

Parent's Request for Administration of Prescription Medication at School

STUDENT NAME: ____
DIAGNOSIS____
MEDICATION ____
DOSAGE___________________________ FREQUENCY ___________________________________
SPECIAL INSTRUCTIONS: ____

I authorize the School Nurse to administer the above medication:

_______________________________________ _______________________________________
Signature of M.D./Print Name Signature of Parent

_______________________________________ _______________________________________
Date Date

____
____
____
Address and Phone Number of M.D.

I certify that this student has asthma or another life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

BOTTOM PORTION OF FORM TO BE FILLED OUT IF STUDENT SELF-MEDICATES

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school-related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurse and other school employees against any claims arising from the self-administration of medication by my child.

Date: ___________________________ Parent/Guardian Signature: __________________________

NOTE: All medication is to remain in the Health Office and not on the person of the student unless requested by a note from the physician and parent.