



September 2018

Dear Parent/Guardian,

Listed below is an explanation of the various medical permission slips. Please review and complete the checklist at the bottom portion of this form by placing a checkmark next to those permissions you are granting the school physician, school nurse, and/or school psychiatrist.

Sincerely,

  
Jan Maliniak, RN

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I would like my child to have his/her physical conducted by the school physician.

I hereby give the nurse permission to administer medication during the school day to my child. Please complete the attached form with your child's physician.

I hereby give the nurse permission to give my child Tylenol for headache, fever or pain relief or Tums for stomach problems.

If your child's physician prefers Motrin for headache, fever, or pain please acknowledge.

I give permission for my child to be evaluated by the school psychiatrist Dr. Nita Bhatia.

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Child's Name

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Parent/Guardian Signature

**PERMISSION FOR ADMINISTRATION OF MEDICATION**

**PARENT/GUARDIAN SECTION:**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies \_\_\_\_\_

Legal Prescribers'/Physicians' Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

I request that my child receive the medication prescribed below during school hours as authorized by my physician.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

**LEGAL PRESCRIBER SECTION:**

Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_ Route \_\_\_\_\_ Dose \_\_\_\_\_

DAILY Time of Administration: \_\_\_\_\_

PRN Describe indication(s) for administration: \_\_\_\_\_

Time interval for repeat dosage: \_\_\_\_\_

Side effects: \_\_\_\_\_

Intervention for adverse reactions: \_\_\_\_\_

Other information: \_\_\_\_\_

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

Signature of Legal Prescriber \_\_\_\_\_

**\*\*\* Medication prescriptions are effective for one school year only and renewal is required annually. All forms must be on file in the Health office *before* medication can be administered.**

**PERMISSION FOR SELF- ADMINISTRATION OF MEDICATIONS**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies \_\_\_\_\_

Legal Prescribers'/Physicians' Name (print) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**LEGAL PRESCRIBER SECTION:**  
**EPIPEN AND INHALER INSTRUCTIONS**

I have instructed the above student in the use of his/her epipen and/or inhaler and he /she may carry the medication on his/her person and self- administer medication as instructed by me and prescribed on the *Authorization for Medication Administration During School Hours* form.

Legal Prescribers'/Physicians' Name \_\_\_\_\_

Legal Prescribers'/Physicians' Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*Medication prescriptions are effective for one school year only and renewal is required annually. All forms must be on file in the Health office *before* medication can be administered.**

**PARENT/GUARDIAN SECTION:**  
**REQUEST FOR SELF-ADMINISTRATION OF EPIPEN OR INHALER**

I request that my child be permitted to carry and self-administer his/her epipen or inhaler at school, as authorized by the legal prescriber/physician above. I accept full responsibility for making sure that my child carries the drug at all times.

**INDEMNIFICATION/HOLD HARMLESS AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION**

The parent(s) /guardian(s) agree(s) to indemnify, defend, and hold the school district harmless from any and all claims, action, costs expenses, damages and liabilities, including attorney's fees arising out of, connected with or resulting from the self-administration of medication by the pupil. The parent(s) / guardian(s) agree(s) to extend this indemnification/hold harmless agreement to Windsor Bergen Academy employees, and its agents. The parent(s) / guardian(s) agree(s) the school district, Windsor Bergen Academy employees, and its agents shall incur no liability as a result of any injury arising out of or connected with the self-administration of medication by the pupil. The agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be signed and be in full effect prior to the granting of permission to self-administer medication.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_