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MEETING THE SPECIAL NEEDS OF CHILDREN

September 2020

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

_____ 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.

______________________________ Child's Name

______________________________ 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 ________________