

MIDDLESEX COUNTY VOCATIONAL - TECHNICAL HIGH SCHOOLS – PISCATAWAY CAMPUS

21 Suttons Lane, Piscataway, NJ 08854

School Nurse Phone: 732-985-0717 extension 2218 Fax: 732-985-8087

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following sections is to be completed by the PARENT/GUARDIAN:

Student Name: _____
Last First Sex Date of Birth

Physician Name: _____
Print Name Phone Number

WAIVER OF LIABILITY

We request that our child be assisted in taking the medication described below at school by authorized person or permitted to medicate him/herself as also authorized by my physician and by me.

We, as the parents and natural guardians of said child request that the Middlesex County Vocational-Technical High schools permit our child to carry and use an Inhalers and/or EpiPen while on school property at an approved school event. We agree to comply with the regulations of the school district and in consideration of the privilege extended to us and our child, we hereby agree to indemnify and hold harmless the Board of Education of the Middlesex County Vocational-Technical High School and its employees from and against any and all losses, claims, damages or expenses arising from or growing out of the acceptance by the Board of the request recited above. We also agree to provide an additional Inhaler or EpiPen, identical to the one which the pupil is authorized to carry, which shall be retained by the school Nurse in accordance with school policy.

Parent/Guardian Signature _____ Date _____

Please note: ALL MEDICATION ORDERES ARE ONLY GOOD FOR ONE SCHOOL YEAR.

THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

DIAGNOSIS _____

MEDICATION _____

DOSE _____

ROUTE _____

TIME OF DAY _____

HOW OFTEN MAY DOSE BE REPEATED PER DAY? _____

LIST OF SIGNIFICANT SIDE EFFECTS _____

OTHER INDICATIONS _____

Is the child authorized to self-medicate? (For EpiPen and Inhaler use only) please circle YES or NO

Is child authorized to carry Inhaler/EpiPen on their person? please circle YES or NO

Has child been instructed in the proper use of Inhaler/EpiPen? please circle YES or NO

OTHER PERTINENT INFORMATION _____

Physician's PRINTED NAME

Date

Physician's Signature

stamp