MIDDLESEX COUNTY MAGNET SCHOOLS – PISCATAWAY MAGNET SCHOOL
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 Magnet 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 Magnet 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.
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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