MIDDLESEX COUNTY MAGNET SCHOOLS - WOODBRIDGE ACADEMY MAGNET SCHOOL

1 Convery Blvd., Woodbridge, NJ 07095
School Nurse Phone: 732-634-5858 ext. 3018 Fax: 732-360-5642

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student Name:_____
Last First DOB

Healthcare Provider Name:_____
Print Name Phone Number

WAIVER OF LIABILITY: I request that my child be assisted in taking the medication described below at school by authorized persons, or permitted to medicate him/herself, as authorized by me and by my child's healthcare provider. I, as the parent and natural/legal guardian of named child, request that the Middlesex County Magnet Schools permit my child to carry and use an emergency inhaler and/or Epipen while on school property, or while off school property at an approved school event. I agree to comply with the regulations of the school district and in consideration of the privilege extended to me and my child, I hereby agree to indemnify and hold harmless the Board of Education of the Middlesex County Magnet Schools and its employees from and against any and all losses, claims, damages, or expenses arising from the acceptance by the Board of the request recited above. I also agree to provide an additional inhaler or Epipen, identical to the one which my child is authorized to carry and self-administer, which shall be retained by the school nurse in accordance with the school's policy.

Parent/Guardian Signature/Date:_____

PLEASE NOTE: ALL MEDICATION ORDERS MUST BE RENEWED EACH SCHOOL YEAR
*** A SEPARATE FORM MUST BE COMPLETED FOR EACH MEDICATION REQUIRED ***

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THE FOLLOWING SECTION IS TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

Diagnosis:
Medication:
Dose/Route:
Day/Time:
Instructions for repeat dose, if applicable:
List significant side effects:
Length of time this medication is required:
Other pertinent information:
For EPIPEN and ASTHMA INHALER Only: Is child authorized for self-administration and/or self-carry of Epipen/Inhaler? □ **YES** □ **NO** Has child been instructed and observed for proper use of Epipen/Inhaler? □ **YES** □ **NO**

Healthcare Provider Name (Print):_____

Healthcare Provider Signature/Date:_____ Stamp: