Saint James
Elementary School

30 Peters Place
Red Bank, NJ 07701

SAINT JAMES ELEMENTARY SCHOOL
AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

PERMISSION FOR SELF- ADMINISTRATION OF MEDICATIONS

Name of Student_____ _____Date of Birth
Grade / Teacher_____ ___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 (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, the Diocese of Trenton, the school administrators and its employees or agents of St. James School and its employees harmless from any and all claims, action, costs expenses, damages and liabilities, including claims for its negligence or gross negligence, and including attorney's fees arising out of, connected with or resulting from 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 _____

Home Phone_____ Emergency Phone_____