EAST BRUNSWICK

Michael Cappiello, *Principal*
Jason Garzone, *Assistant Principal*
Joseph Adochio, *Assistant Principal*
Kelly Nakielny, *Assistant Principal*

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

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

Student Name:_____
Last First 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 an authorized person or permitted to medicate themselves as also authorized by their physician and me.

We, as the parents and natural guardians of said child, request that the Middlesex County Magnet Schools permits our child to carry and use an inhaler and/or Epipen while on school property or at an approved 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 Schools 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 ORDERS ARE ONLY GOOD FOR ONE SCHOOL YEAR

****

THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

DIAGNOSIS_____
MEDICATION_____
ROUTE_____
TIME OF DAY_____
HOW OFTEN MAY DOSE BE REPEATED PER DAY_____
LIST OF SIGNIFICANT SIDE EFFECTS_____
OTHER INDICATIONS_____

FOR EPIPENS AND INHALERS ONLY	**PLEASE CIRCLE**
Is the child authorized to self-medicate?	YES or NO
Is the child authorized to carry the inhaler/Epipen on their person?	YES or NO
Has the child been instructed in the proper use of Inhaler/Epipen?	YES or NO

OTHER PERTINENT INFORMATION

_____

Physician's Name_____ Date:_____

Physician's Signature_____ DOCTOR'S STAMP: