60 West Midland Ave. • Paramus, NJ 07652
Phone: 201-523-9533 Fax: 201-523-9534
WindsorPrepHS.com

MEETING THE SPECIAL NEEDS OF CHILDREN

September 2018

Dear Parent/Guardian,

Listed below is an explanation of the various medical permission slips. Please review and complete the checklist at the bottom portion of this form by placing a checkmark next to those permissions you are granting the school physician, school nurse, and/or school psychiatrist.

Sincerely,
Ellen Maffei
Ellen Maffei
School Nurse

_____ I would like my child to have his/her physical conducted by the school physician.

_____ I hereby give the nurse permission to administer medication during the school day to my child. Please complete with your child's physician the attached form.

_____ I hereby give the nurse permission to give my child Tylenol for headache, fever or pain relief or Tums for stomach problems.

_____ I give permission for my child to be evaluated by the school psychiatrist Dr. Nita Bhatia.

_____ _____
Child's Name Parent/Guardian Signature

PERMISSION FOR ADMINISTRATION OF MEDICATION

PARENT/GUARDIAN SECTION:

Name of Student_____ Date of Birth_____

Allergies_____

Legal Prescribers'/Physicians' Name_____

Address _____Phone _____

I request that my child receive the medication prescribed below during school hours as authorized by my physician.

Signature of Parent/Guardian _____ Date_____

Home Phone_____ Emergency Phone_____

LEGAL PRESCRIBER SECTION:

Diagnosis_____

Medication_____ Route _____ Dose _____

- ❑ DAILY Time of Administration: _____
- ❑ PRN Describe indication(s) for administration: _____

_____

Time interval for repeat dosage: _____

Side effects:_____ Intervention for adverse reactions: _____

Other information: _____

_____

Date prescribed:_____ Date discontinued: _____

Signature of Legal Prescriber _____

***** 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.**

PERMISSION FOR SELF- ADMINISTRATION OF MEDICATIONS

Name of Student _____ Date of Birth_____
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 district harmless from any and all claims, action, costs expenses, damages and liabilities, including attorney's fees arising out of, connected with or resulting from the self-administration of medication by the pupil. The parent(s) / guardian(s) agree(s) to extend this indemnification/hold harmless agreement to Windsor Prep High School employees, and its agents. The parent(s) / guardian(s) agree(s) the school district, Windsor Prep High School employees, and its agents shall incur no liability as a result of any injury arising out of or connected with 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_____