# Little Falls Township Public Schools
## Permission Form for Prescribed and Non-Prescribed Medication

Student:_____ Date of Birth:_____ Today's Date:_____
Grade:_____ Teacher:_____

**To be completed by the authorized Healthcare Provider**
Name of medication:_____
Reason for medication:_____

Dose & Frequency of medication/treatment:_____ Form of medication/treatment:
_____Tablet / Capsule _____Liquid _____Inhaler _____Injection _____Nebulizer _____Other

Instructions: Dose and schedule to be given
Start: _____date form received _____other start date:_____
Stop: _____end of school year _____other end date/duration __For episodic / emergency events only

Restrictions and/or important side effects: _____None anticipated
_____Yes –Please describe:_____ Special storage requirements: _____None _____Refrigerate _____Other

Self-Administration of Medication as per N.J.S.A. 18A:40-12.3 the student may only self-administer medication for Asthma and other potentially life-threatening illnesses as defined by the NJDOE. (example: Auto-Injector Epinephrine)

*This student is both capable and responsible for self-administering this medication:
_____No _____Yes –Supervised _____Yes –Unsupervised
This student may carry and self-administer this medication: _____No _____Yes –(If yes, please supply back-up med to school nurse, in case student forgets/loses his/her medication) _____**Parent Initials**

*Only students diagnosed with asthma may obtain permission to carry and self-administer medication prescribed for that disease.
_____Please check if you have provided/attached additional information.

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Healthcare Provider's Name:_____
Address:_____
Telephone Number:_____

**Healthcare Provider's Signature:**_____ Date:_____
**To the school:** Please report concerns about medications or disease to the above healthcare provider.

**To be completed by Parent/Guardian:**
I give permission for (name of child) _____ to receive the above medication during school hours; according to Little Falls Board Policy #5330, "Administration of Medication."
*(All medication administered by a New Jersey Certified School Nurse must be sent to school in its original container with a current date).*

Date:_____ **Parent Signature:**_____ Relationship:_____
**The Parent/Guardian acknowledges by signing this form that the district and its employees shall incur no liability as a result of any injury arising from the self-administration by the pupil and the Parents/Guardians shall indemnify and hold harmless the district and its employees against any claims arising out of the self-administration by the pupil. Any person who acts in good faith in accordance shall be immune from any civil or criminal liability arising from actions pursuant to this act. N.J.S.A. 18A:40-12.3**
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