Ronald F. Corn,
High School Principal
Michael J. Renner,
Assistant Principal
Eric Rosen,
Assistant Principal
Joseph C. Cramp, Jr.,Director of
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HADDON HEIGHTS
Junior/Senior High School

301 Second Avenue, Haddon Heights, NJ 08035 ● (856) 547-1920 / FAX (856) 547-6808

SELF-MEDICATION DISPENSING FORM
FOR STUDENTS WITH ASTHMA OR
OTHER POTENTIALLY LIFE-THREATENING EMERGENCIES

Students Name _____ Age _____ Grade _____ School

Name of Medication _____ Prescription _____ Non-Prescription

Dosage _____ Frequency

Route of Administration _____ Reason for Medication

Known Allergies:

Possible Side Effects:

Effective dates (limited to one school year) from _____ 20 ____ to _____ 20 __
It is my understanding that the school nurses of the Haddon Heights School District charge with the administration of medication may rely upon my directions as contain in this document. Students with asthma or other potentially life threatening illnesses, deemed sufficiently responsible by their parents/guardians, shall be permitted to have in their possession prescribed medication for the treatment and prevention of life threatening illnesses or conditions during school hours, athletic events and practices, and field trips. **I hereby deem the above-named student to be sufficiently capable, having been instructed in the proper method of self-administration of medication pursuant to chapter 308 of the laws of 1993, to carry his/her prescribed medication on his/her person and give authorization for self-medication of the medication listed above.** I further certify that I am the physician who prescribed the medication and the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

_____ YES _____ NO This drug may be omitted on half-days and field trips.

_____ _____
Physician's Name (Print) Physician's Signature (Stamped signature is **NOT** acceptable

_____ _____ _____
Address Telephone Date

As parents/guardians of the above named child, we/I hereby request permission for our/my child to self-administer and have possession of his/her medication as described above. We/I understand that the school district and its employees and agents shall incur no liability as a result of any injury arising from self-medication by our/my child. We/I further understand that we/I hereby indemnify and hold harmless the school district and its employees and agents against claims arising our of our/my child's self-administration of medication. We/I realize self-management privileges are lost if he/she does not used the medication properly or responsibly. Students deemed responsible may carry their prescribed medication on their person, but must report to the school nurse with the above prescribed medication before this policy can instituted. We/I also authorize the school nurse to contact the above name physician with questions concerning my child's condition or medication. We/I also realize that we/I must renew this certificate annually.

Signature _____ Date _____

Signature _____ Date_____
NOTE: MEDICATION BROUGHT TO SCHOOL MUST BE LABELED.

Office Stamp: _____

H:nurseforms:selfmedi

Our Mission

The Haddon Heights Public Schools will educate students to approach the future as confident, creative, ethical, and productive individuals by providing challenging and enriching learning experiences.

An Equal Opportunity Employer