

**NEWTON PUBLIC SCHOOLS
REQUEST FOR SELF-ADMINISTRATION OF MEDICATION**

Student's Name _____ D.O.B. _____ Date _____

School _____ Grade _____

Parents'/Guardian Name _____ Tel. No. (work) _____

***** PERMISSION IS EFFECTIVE FOR THE SCHOOL YEAR FOR WHICH IT IS GRANTED AND IS RENEWED FOR EACH SUBSEQUENT YEAR UPON COMPLETION OF A NEW FORM**

To be completed by Physician: (please print)

I am recommending that the above-named student be allowed to self-administer the following medication for asthma or other potentially life-threatening illnesses.

Identification of Medical Problem: _____

Name and purpose of medication : _____

Proper timing and dosage of medication: _____

Length of time medication must be taken: _____

Possible side effects and/or special precautions to be taken: _____

Conditions under which self-administration will take place:

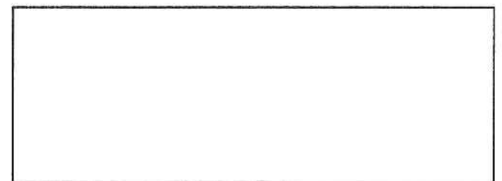
Trainer's name: _____ Date of Training: _____

_____ Independently. Child must have had training and be proficient in self administering medication.

_____ Under the supervision of the nurse.

Medications should be _____ stored in the nurse's office

_____ in the possession of student



Physician Stamp

Physician's Name (print)

Physician's Signature

Physician's I.D. Number

Date

Telephone Number

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To be Completed by Parent: I give my permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician. I acknowledge that the Newton Board of Education shall incur no liability as a result of any injury arising from the self-administration of medication of the pupil and that I hold harmless the district and its employees or its agents any claims arising out of self-administration of medication by my child.

Parent Signature

To Be Completed by Newton's Medical Inspector:

I have reviewed this request for self-administration of emergent medication and recommend that it

- 1) be approved _____

- 2) not be approved _____

If 2 checked, please state reason:

Signature of Medical Inspector

Date

If approved by Medical Inspector.

Signature of Nurse

Date