

Roselle Park Public Schools
Roselle Park, NJ 07204
"Committed to Excellence"

RECOMMENDATION OF PRIVATE PHYSICIAN FOR STUDENT
SELF ADMINISTRATION OF
EPINEPHRINE AUTO INJECTOR OR
EPINEPHRINE AUTO INJECTOR WITH BENADRYL (Single unit dose)

TO BE COMPLETED BY THE PHYSICIAN:

In order to protect the health of _____ Class _____
(Student's name)

it may be necessary for him/her to use an Epinephrine Auto Injector in the case of anaphylactic shock.

Allergen: _____

Previous Symptoms: _____

Epinephrine Jr. (0.15mg) IM **Epinephrine Sr.** (0.30 mg) IM

Side Effects: _____

Benadryl Dosage _____ PO. Side Effects: _____

The above named student has received instructions in the use of the Epinephrine Auto Injector with or without Benadryl and has demonstrated confidence and competence in self-administration. Failure to receive immediate medical treatment will result in a medical emergency. I, therefore, recommend that he/she be allowed to carry and self-medicate with the Epinephrine Auto Injector with or without Benadryl as described above.

Physician's Name (please print) Physician's Signature Date

TO BE COMPLETED BY THE PARENT:

I give permission for my child to self-medicate as described above. I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damages which may result to the student, his/her servants, and representatives which may result from administration of the medication. I will be fully responsible for keeping track of the expiration date of the medication and replacing it when it has expired.

MY CHILD ATTENDS THE ROSELLE PARK BOARD OF EDUCATION EXTENDED DAY PROGRAM ____ YES ____ NO

(Parent/Guardian Signatures) Date School

(Parent/Guardian Signatures) Date School

MEDICATION CONTRACT

Date: _____ Name of Medication: _____

1. I understand that I will use this medication as directed by my physician.
2. I will carry the medication with me at all times, including outside during gym classes, on field trips, and at all athletic events. The medication will be easily accessible. I will be responsible in using it. I understand that if I do not have my medication with me during practices, games, events, etc. I will be excluded from participating in the activity.
3. I have been instructed how to self-administer this medication and understand the side effects and effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shared with anyone else.
4. I will notify teacher/supervisor/coach immediately upon use of the medication. 9-1-1 will be called. The School Nurse will be notified as soon as possible.
5. I understand that if I do not abide by the regulation, I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of the school year.

Student's Signature _____ Date _____

Parent's Signature _____ Date _____