VERNON TOWNSHIP PUBLIC SCHOOLS

Cedar Mountain School
Kim Forrest RN
973-764-8781
Fax# 973-764-3294

Rolling Hills School
Jen Gallant RN
973-764-5590
Fax# 973-764-0841

Lounsberry Hollow School
Debbie Lisa RN
973-764-4920
Fax# 973-764-0101

Glen Meadow Middle School
Stephanie Ash RN
973-764-4661
Fax# 973-764-0851

Covid 19 Coordinator
Kim Muller RN

Vernon Twsp. High School
Cathy Toth, RN
District Nursing Coordinator
974-764-5944
Fax# 973-764-0858

AUTHORIZATION FOR SELF-ADMINISTRATION FOR ASTHMA OR POTENTIALLY LIFE- THREATENING ILLNESSES (DIABETES, ASTHMA, ALLERGIC REACTIONS, ETC.)

To be completed by the parent/guardian (please print or type):

Student's Name_____ Parent/Guardian Name_____

Physician's Name_____ Address_____

Telephone#:_____ Fax #:_____

I request that the above named student, as authorized by the physician below, be permitted to self- administer medicines indicated below. Only enough medication for that school day is to be carried by the student, which is to be pre-measured and in the original prescription containes. The privilege of self-administration of medication may be revoked if the pupil fails to comply with school policy or this agreement or endangers himself/herself or other. I understand and agree in making this request that neither Vernon Township School District nor its staff shall incur liability as a result of any injury/reaction arising from the self-medication. This permission is effective for the current school year.

Date:_____ Parent/GuardianSignature:_____

Home Phone: _____ Emergency Phone:_____

The following must be completed by the Physician:

Diagnosis of the potentially life threatening illness or allergic reaction (specify)_____

_____

Medications_____ Form (ex. pill) _____

Dose: _____ Must the medication be administered during the school day_____

If given daily, what time? _____ If PRN_____

Describe Medications_____

How soon may it be repeated? _____ List significant side effects_____

_____

Length of time this treatment is prescribed_____

Is the child capable of self-administration of medication? _____ Has the child been instructed on the proper use of the medication? ___

Other information_____

Physician Signature_____ Date_____