Lebanon Township School District

Asthma Treatment Plan Addendum

To be completed by the parent/guardian:

Students Name: _____ **School Year 20_____/20_____**

Medication (as named on the Asthma Treatment Plan): _____

Medication orders are effective for the school year for which it is granted and must be renewed annually.

PARENT ACKNOWLEDGEMENT AND AUTHORIZATION:

For Nurse administered Medication:

- I give permission for my child to receive medication at school **as prescribed in the Asthma Treatment Plan.**
- Medication must be provided in its original prescription container properly labeled by a pharmacist or physician.
- I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications.
- In addition, I understand that this information will be shared with school personnel on a need- to- know basis.

Please note: This medication will only be available during the regular school day unless your child has permission to self administer his/her asthma medication. The use of medication on field trips is addressed on the field trip permission form.

_____ _____

♦ **Parent/Guardian Signature** **Date**

For Student self-administering Medication:

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF ADMINISTER ASTHMA MEDICATION ON THE ASTHMA TREATMENT PLAN.

☐ **I DO** request that my child be allowed to carry the medication as stated above for self administration in school pursuant to N.J.A.C. 6A:16-2.3.

- I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication.
- **Medication must be kept in its original prescription container.**
- I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self- administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.
- I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications.

☐ **I DO NOT** request that my child self-administer his/her asthma medication.

_____ _____

♦ **Parent/Guardian Signature** **Date**

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