



# WEST ESSEX REGIONAL SCHOOLS

## PART 2: To be completed by Parent/Guardian

### Emergency Contacts:

Name/Relationship Phone Number(s):

a. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_

b. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_

c. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_

### **A. Parent/Guardian Permission for School Nurse Administration of Medication**

**To be completed by Parent/Caregiver:** I give my permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required.

I disclaim all liability of the West Essex Board of Education as it concerns the use of this medication.

**I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.**

\_\_\_\_\_  
Parent/Caregiver Signature

\_\_\_\_\_  
Date

### **B. Parent/Guardian Permission for Self-Administration of Epi-Pen and/or Benadryl**

**To be completed by Parent/Caregiver:** I give my permission for my child to self-administer the medication **as described on the reverse side.** I will notify the school nurse immediately if this medication is no longer directed by the physician.

I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self administration of medication by the pupil.

**I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### **C. Student Agreement for Self-Administration**

**To be completed by the student:** I understand that I will use this medication as directed by my physician. I will be responsible and discreet using the medication as described on the reverse side and should have this medication readily accessible. I have been instructed how to self-administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container.

**I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer this medication.** I disclaim all liability of the West Essex Board of Education as it concerns my use of this medication.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

### **D. Treatment by Delegate When Nurse Not Present**

NJ State Assembly Act Senate No. 79 directs that the school nurse shall designate additional employees of the school district who volunteer to administer a one time dose of epinephrine to a pupil for anaphylaxis when the nurse is not physically present at the scene. I give my permission for a delegate to be assigned to my child in the event a nurse, or myself are not present. I disclaim all liability of the West Essex Board of Education and its employees as it concerns the use of this medication.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date