SOUTH HARRISON TOWNSHIP SCHOOL DISTRICT
Food Allergy Medication Dispensing Form

student listed below is under my medical care. His/her treatment requires dispensing medication during school hours as stated below:

Student's Name ____

Reason for Medication ____

*Name of Medication ______________________________(antihistamine)

Dosage___________________________________ Time to be administered_________________

Effective dates from ____________________________ to ________________________________

Route of Administration ____

Specific instructions ____

Precautions / Side Effects ____

*Name of Medication ______________________________(epinephrine)

Dosage___________________________________ Time to be administered_________________

Effective dates from ____________________________ to ________________________________

Route of Administration ____

Specific instructions ____

Precautions / Side Effects ____

Please note: In the absence of a parent or school nurse, a delegate is not permitted to administer an antihistamine (if ordered); therefore epinephrine will be administered if signs or symptoms of an allergic reaction are noted.

It is my understanding that the school nurse, charged with the administration of medication, may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment.

Date ________________ Physician's signature ____

Print physician's name and title ____

Parental Permission

Medication has been prescribed for my child, ____. As parent/guardian, I hereby request the administration of the medication described above to my child and release the South Harrison Township School District and its employees of any responsibility or liability in giving this medication. I understand the medication brought to school must be labeled and in the original container. I also understand that the nurse or I are unable to accompany my child on school trips, a designee will administer epinephrine if signs or symptoms of an allergic reaction are noted.*

Date _______________ Signature of Parent / Guardian ____

____ I give my permission for the SHTES nurse to speak with my child's physician.

* NB: NJ JERSEY STATE LAW ALLOWS CHILDREN TO SELF-MEDICATE FOR LIFETHREATENING CONDITIONS ONLY. YOUR PHYSICIAN MUST CERTIFY IN WRITING, THAT THE PUPIL, THE PARENT/GUARDIAN, OR DESIGNATED ADULT IS CAPABLE OF ADMINISTRATING THE MEDICATION. IF A CHILD IS ALLOWED TO SELF-MEDICATE, OUR SCHOOL WILL ALLOW THEM TO DO SO UNDER THE SUPERVISON OF A DESIGNATED ADULT.