WATCHUNG HILLS
REGIONAL HIGH SCHOOL

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2014 New Jersey Revised Statutes
Title 18A - EDUCATION
Section 18A:40-12.3 - Self-administration of medication by pupil permitted.

Universal Citation: NJ Rev Stat § 18A:40-12.3 (2014)

18A:40-12.3 Self-administration of medication by pupil permitted.
1. a. A board of education or the governing board or chief school administrator of a nonpublic school shall permit the self-administration of medication by a pupil for asthma or other potentially life-threatening illnesses, a life-threatening allergic reaction, or adrenal insufficiency provided that:

(1) **the parents or guardians of the pupil provide to the board of education or the governing board or chief school administrator of a nonpublic school written authorization for the self-administration of medication;**

(2) the parents or guardians of the pupil provide to the board of education or the governing board or chief school administrator of a nonpublic school written certification from the physician of the pupil that the pupil has asthma or another potentially life-threatening illness or is subject to a life-threatening allergic reaction, or has adrenal insufficiency and is capable of, and has been instructed in, the proper method of self-administration of medication;

(3) **the board of education or the governing board or chief school administrator of a nonpublic school informs the parents or guardians of the pupil in writing that the district and its employees or agents or the nonpublic school and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil;**

(4) the parents or guardians of the pupil sign a statement acknowledging that the district or the nonpublic school shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that the parents or guardians shall indemnify and hold harmless the district and its employees or agents or the nonpublic school and its employees or agents against any claims arising out of the self-administration of medication by the pupil; and

(5) the permission is effective for the school year for which it is granted and is renewed for each subsequent school year upon fulfillment of the requirements in paragraphs (1) through (4) of this subsection.

b. Notwithstanding any other law or regulation to the contrary, a pupil who is permitted to self-administer medication under the provisions of this section shall be permitted to carry an inhaler or prescribed medication for allergic reactions, including a pre-filled auto-injector mechanism, or prescribed medication for adrenal insufficiency at all times, at all times, provided that the pupil does not endanger himself or other persons through misuse.

c. Any person who acts in good faith in accordance with the requirements of this act shall be immune from any civil or criminal liability arising from actions performed pursuant to this act.

Per the above information, I grant my Child _____,

Permission to self-carry and self- administer their prescribed medication during school hours and during athletic or school sponsored events.

I acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by my child 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.

Parent/Guardian Signature: _____ Date: _____

Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [○ Mild ○ Moderate ○ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

GREEN ZONE: GO! — Take These DAILY CONTROLLER MEDICINES (PREVENTION) Medicines EVERY DAY

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s): _____

☐ _____

Take _____ puff(s) or _____ tablet(s) _____ daily.

☐ For asthma with exercise, ADD: _____,

_____ puffs with spacer _____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION! — Continue DAILY CONTROLLER MEDICINES and ADD QUICK-RELIEF Medicines

You have ANY of these:
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ _____ inhaler _____ mcg

Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml

Take a _____ nebulizer treatment every _____ hours, *if needed*.

☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY! — Continue DAILY CONTROLLER MEDICINES and QUICK-RELIEF Medicines and GET HELP!

You have ANY of these:
- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ _____ inhaler _____ mcg

Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml

Take a _____ nebulizer treatment every _____ hours, *if needed*.

☐ Other _____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____ – _____.

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan [illegible]

Signature _____ Date _____

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION

RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

Student Name: _____ DOB: _____ Grade: _____
Emergency Contacts: (Name and Phone#'s):_____
_____

I. Parental/Guardian Consent for Administration of Asthma medication

___**I request that my child be ALLOWED to carry and self-administer in school**, his asthma medication listed below pursuant to N.J.S.A. 18A:40-12.3 and 12.4. I give permission for my child to self-administer his/her medication, as prescribed on this form for the current school year. I consider him/her to be responsible and capable of transporting, storing and self-administrating the medication. 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 do not request that my child self-administer his asthma medication.** I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. 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 administration or lack of administration 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 administration or lack of administration of this medication.

_____ _____ _____
Parent/Guardian Signature Telephone Date

.. Healthcare Provider Order:

Name of medication: _____

Dosage: _____ Route: _____ Frequency:_____

For Student Self Administration:
_____This student has been instructed in and is capable of proper method of self-administration of the medication prescribed above.
_____This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.

____This student is **not** approved to self-medicate

_____
Physician's Name Signature Date

Office Stamp:

This form must be individually completed for **all medications**.
Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy.
All medications **will be kept** in a locked storage area.