WATCHUNG HILLS
REGIONAL HIGH SCHOOL

ELIZABETH C. JEWETT, PHD
SUPERINTENDENT

TIMOTHY M. STYS, CPA
BUSINESS ADMINISTRATOR

WILLIAM J. LIBRERA
PRINCIPAL

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: _____

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION | END EPILEPSY