Authorization for Self-Administration of Asthma Inhaler/ Epinephrine/Hydrocortisone Sodium Succinate by Student

Student Name: ____ Grade: _____________

Student's date of birth: _____________________________ School Year: ___________________

☐**Asthma** ☐ **Adrenal Crisis** ☐ **Life Threatening Allergy: _______________________________________**

The minor individual named above is my patient. I understand that this patient is a student in your school.

I further understand that pursuant to the provisions of N.J.S.A. 18A:40-12.4 allows the parent(s)/guardian(s) of a student who has asthma, a potentially life threatening allergy, or adrenal crisis to authorize self-administration of an asthma inhaler, epinephrine, or hydrocortisone sodium succinate by the student providing the student's physician certifies to the school that the student is capable of, and has been instructed in, the proper method of self-administration of this medicine.

My patient has asthma, a known allergy and is at risk for a life-threatening reaction or is at risk for adrenal crisis requiring the use of an asthma inhaler, epinephrine auto-injector, or hydrocortisone sodium succinate.

My patient is capable of, and has been instructed in, the proper method of self-administration of an asthma inhaler, epinephrine auto-injector, or hydrocortisone sodium succinate. If the medication which I have prescribed is changed in the future, I will either assure that my patient remains capable of and has been instructed in the proper method of self-administration of said medication or will notify the school that my patient is no longer capable of, or has not been instructed in, the proper method of such self-administration.

I understand that the authorization by my patient's parent(s)/guardian(s) is effective only for the current school year and must be re-authorized by them for each future school year. Any such re-authorization by my patient's parent(s)/guardian(s) for any future school year must be accompanied by a new certification by me. *"Physician" refers to all Health Care Providers licensed as MD, DO, APN, & PA.

Medication(s): ____

Physician's Signature: ____ Date: ______________________

Physician's Name (print): ______________________________________Phone #: ___________________

We, the undersigned, are the parent(s)/guardian(s) of the student named above.

We have been advised by you that legislation has been enacted allowing parent(s)/guardian(s) of a student with a diagnosis of asthma, a potentially life-threatening allergy, or risk for adrenal crisis to authorize self-administration of an asthma inhaler, epinephrine, or hydrocortisone sodium succinate by the student so long as the student's physician certified to you that the student is capable of, and has been instructed in, the proper methods of self-administration. We have also been advised by you that if we do not give this authorization, the school and its employees and agents will incur no liability because of any injury arising from self-administration of an asthma inhaler, epinephrine, or hydrocortisone sodium succinate by the student.

The student named above has asthma, a known allergy and is at risk for a life-threatening allergic reaction or is at risk for adrenal crisis and is required to take the medication listed above. We authorized the student named above to self-administer an asthma inhaler, epinephrine, or hydrocortisone sodium succinate while the student is under your jurisdiction.

We acknowledge that the school and its employees/agents shall incur no liability as a result of any injury arising from the self-administration of an asthma inhaler, epinephrine, or hydrocortisone sodium succinate by the student and we agree to indemnify and hold harmless the school and its employees/agents against any claims arising out of the self-administration of the prescribed medication.

We understand that this authorization only applies to the current school year. We have the right to choose whether to furnish a new authorization for each school year.

Parent/Guardian Signature: _____________________________________ Date: ___________________

Parent/Guardian Name (print): __________________________________ Phone #: _________________

*This form is not valid unless signed/dated by both parent and physician.