WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

____HSS ____HSN ____Grover MS ____Community MS

____Millstone River ____Village ____ Hawk ____DN

____Wicoff ____ Town Center

Please check one

Prescription Form for Administration of Medication in School

Student's Name_____**D.O.B.**_____ **Grade**_____

Diagnosis _____

Name of Medication _____ **Dosage**_____

Time and Circumstances of Administration_____

Possible side effects:_____

Length of time the prescription is valid _____**(May not exceed the school year)**

When specific guidelines are followed, a student may self-administer medication. Self-administration of a prescribed medication is permitted only in exceptional circumstances when a life threatening condition exists. For purposes of the Board policy life threatening illness is defined as, "*...an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthmatic attack or the use of an adrenaline injection to treat a potential anaphylactic reaction.*"

When self-administration of medication is applicable for a life threatening condition and in accordance with West Windsor-Plainsboro School District policy guidelines are as follows:

Grades **K-3** – No student will be allowed to self-administer medication without the assistance of a nurse.
Grades **4-5** – A student will be allowed to use inhalers without nurse assistance on field trips **only**.
Grades **6-12** – A student may self-administer medication for life threatening illnesses.

_____ is capable and has been instructed in the proper method of
Student's name

self administration of _____as directed.
Medication

When an auto-injector is prescribed, please provide the following information:

Is there a documented history of anaphylaxis? Yes_____ No_____

If yes, please provide the signs/symptoms of this child's anaphylactic episode(s)_____

_____ _____ _____

SIGNATURE OF PHYSICIAN/DENTIST **DATE** **PHONE**

_____

PHYSICIAN/DENTIST NAME (PRINT/TYPE/STAMP)