



Any restrictions the medication might make on the Student's daily activities (e.g.: physical education). ·

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If the medication is to be used on a "pm" or "as needed" basis, the order should clearly describe the conditions under which the drug is to be used:

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Other medications the Student receives that might enhance, alter or impact the effects of the ordered medication.

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This medication is:

Over-the-counter medication:     Yes     No

Prescription medication:         Yes     No

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

***(see next page for the parent acknowledgment and agreement)***

## **PARENT/GUARDIAN ACKNOWLEDGMENT & AUTHORIZATION**

### **Administration of Medication, Generally**

I, \_\_\_\_\_, am the parent/guardian of the Student identified above, and for whom I authorize the North Haledon School District, through its authorized staff members, to administer the medication specified in this form.

Prior to signing this authorization, I have had the opportunity to read the Board of Education's Policies and Regulations pertaining to the administration of medication (5330), including medical marijuana (5330.01); administration of opioid antidote (5330.04); management of life-threatening allergies (5331); treatment of asthma (5335); and diabetes management (5338). I acknowledge that these policies and regulations are available for review on the Board of Education website: <https://www.nhschools.net/nh/Board/Board%20Policies/>, and hard copies are available at each school nurse's office and through the Board office. I have also had the opportunity to ask questions regarding those policies and regulations.

In having reviewed and in understanding those policies and regulations, I am fully aware of my and the Board of Education's responsibilities in administering medication and other health services to my child, the Student, and in accordance with the above

***I hereby grant permission to the school nurse to distribute medication to my child \_\_\_\_\_***

***\_\_\_\_\_  
("Student") as described above.***

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Parent Guardian Signature

Date

### **Administration of Epinephrine or Administration of Hydrocortisone Sodium Succinate**

I, \_\_\_\_\_, am the parent/guardian of the Student identified above. I acknowledge and understand that, should the administration of epinephrine or hydrocortisone sodium succinate be reasonably necessary, and the Student is injured or suffers harm as a result, the North Haledon Board of Education, including its officers, employees and agents ("Board"), shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism or the administration of hydrocortisone sodium succinate to the Student. In addition, I, on behalf of myself and heirs, and on behalf of the Student, indemnify and hold harmless the Board against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism or the administration of hydrocortisone sodium succinate to the student.

### ***Parent Acknowledgment & Agreement:***

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Parent Guardian Signature

Date