



MONMOUTH OCEAN EDUCATIONAL SERVICES COMMISSION  
**Department of Special Services**

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**Stacy Costa**  
Director of Special Services

**MEDICAL RELEASE FORM**

**Self Medication Order for Inhaler Only**

The administration of medication to a child during the before and after school SACC Program will be permitted only when the child's physician certifies in writing that the administration of medication during the before and after school SACC Program is essential to the health of the child and may be self-administered by the child safely. The parent/guardian must provide a written request for the self-administration of the prescribed medication.

**Part I – To Be Completed In Full By the Child's Physician**

I certify that it is essential to the health of \_\_\_\_\_ that the following medication be administered during the before and after school SACC Program.

DIAGNOSIS: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE/MODE/FREQUENCY: \_\_\_\_\_

SIDE EFFECTS, if any: \_\_\_\_\_

PERMISSION IS GRANTED FOR SELF-MEDICATION BY THE CHILD. THE CHILD HAS BEEN TRAINED AND IS PROFICIENT IN SELF-ADMINISTRATION OF PRESCRIBED MEDICATION, WHICH MAY BE ADMINISTERED BY THE CHILD SAFELY.

LENGTH OF TIME THE ORDER IS VALID (may not exceed the school year): \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

**PART II – To Be Completed By the Child’s Parent/Guardian:**

I hereby request self-medication privileges for my child\_\_\_\_\_.  
He/she has received instruction in and will demonstrate correct procedures in the use of the prescribed medicine to me and or his/her personal physician. My child and I are also aware that self management privileges are lost if the child does not use the medication properly. Provided they are informed, the SACC staff will employ their best efforts to report to the school nurse after the child’s use of medication in the form of a self-medication written form. This reporting to the school nurse may take place that day of self medication or the next day. Best efforts will be utilized by SACC to timely notify the parent of the child’s self medication event.

I also understand that the Monmouth-Ocean Educational Services Commission and its employees or agents shall incur no liability as a result of injury arising from the self-administration of medication by the child and, as a consequence, I release and waive any right I may have or cause of action which may arise as a result of self-medication. The parents or guardians shall indemnify and hold harmless the Monmouth-Ocean Educational Services district and its employees or agents against any claims arising out of the self-administration or medication by the child.

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone