

Cape May County Technical School District  
188 Crest Haven Road  
Cape May Court House, New Jersey 18210  
(609) 465-2161 ext. 658

**In accordance with N.J.S.A. 18A:40 - 12.3 et. seq.,  
Self-Administration of Medication for Life Threatening Illness:  
Pancrease Enzymes for the self-care management of Cystic Fibrosis**

**PARENT/GUARDIAN: If you do not supply the annually updated medical plan, your child will not be permitted to participate in sports or any off campus activity, including field trips.**

I certify that: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_  
Name of student - Please Print

is under my care for cystic fibrosis that is a life threatening illness. He/She is capable of and has been instructed in the proper method of self administration of the prescribed medication for this illness.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Physician's Name - Please Print Physician's Signature Date  
\_\_\_\_\_  
Street Address City/Town, State Zip Code Telephone

\_\_\_\_\_  
Name of medication Possible side effects: \_\_\_\_\_

Dose: \_\_\_\_\_ Per # \_\_\_\_\_ fat grams ingested Take orally for snack/meals as needed

**Health Care Provider**, please review with your patient the following responsibilities: Do not share medication. Medications need to be labeled in the original container with name of medication, dose and student name. Only the dose of medication that needs to be taken during the school day should be carried by the student.

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**Guardian completes this section.**

My child has my permission to self-administer the above named medication as directed by the physician. I understand that the Cape May County Technical School District shall incur no liability or claims against the district or its employees as a result of injury arising from my child's use of the self-administered medication.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Guardian's Name - Please Print Signature Date

**Circle** telephone number we should call first: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**In the event you can not be reached at the above telephone number(s) please indicate an emergency contact.**

Person's Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_