

Sandman Consolidated School  
838 Seashore Road  
Cape May, NJ 08204  
Telephone: (609) 884-9410  
Fax: (609) 884-9412

LOWER TOWNSHIP ELEMENTARY SCHOOL DISTRICT

834 SEASHORE ROAD  
CAPE MAY, NEW JERSEY 08204

Maud Abrams School  
714 Town Bank Road  
Cape May, NJ 08204  
Telephone: (609) 884-9420  
Fax: (609) 884-9421

TELEPHONE: (609) 884-9400  
FAX: (609) 884-1821

Memorial School  
2600 Bayshore Road  
Villas, NJ 08251  
Telephone: (609) 884-9430  
Fax: (609) 886-0515

Carl T. Mitnick School  
905 Seashore Road  
Cape May, NJ 08204  
Telephone: (609) 884-9470  
Fax: (609) 898-9481

Dear Parents/Guardians:

I would like you to be aware, that State Law #A-2600 went into effect on December 23, 1993, which, with your signed permission, allows students to "self-administer" medication for asthma or other potentially life-threatening illnesses.

Please indicate below your decision. This letter will be kept on file in the nurse's office for the remainder of this school year. You will be asked again for your decision every September for that school year, as this information must be asked annually.

If you decide to allow your child to "self-administer" their medication, you must produce a physician's note, certifying that the student is capable of, and has been instructed in, the proper administration of the required drug.

Thank you for your immediate attention to this matter.

Sincerely,

*Christina Isenhardt RN*  
Christina Isenhardt, RN  
Sandman School Nurse

PLEASE CHECK OFF YOUR DECISION, SIGN THE LETTER AND SEND IT TO SCHOOL WITH YOUR CHILD.

\_\_\_\_ YES, MY CHILD MAY SELF-ADMINISTER MEDICATION IN SCHOOL AND ON FIELD TRIPS. ATTACHED IS THE PHYSICIAN'S NOTE, CERTIFYING THAT MY CHILD IS CAPABLE OF, AND HAS BEEN INSTRUCTED IN, PROPER ADMINISTRATION OF THE REQUIRED DRUG. I UNDERSTAND THE DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-MEDICATION AND I HOLD THE DISTRICT HARMLESS AGAINST ANY INJURY OR CLAIMS THAT ARISE AS A RESULT OF MY CHILD'S SELF-ADMINISTRATION.

\_\_\_\_ NO, MY CHILD MAY NOT SELF-ADMINISTER MEDICATION.

\_\_\_\_\_  
(Parent/Guardian's Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Childs Name

\_\_\_\_\_  
Teacher