PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

**SELF-ADMINISTRATION OF MEDICATION**
**- Healthcare Provider's Certification -**

**(To Be Completed by Healthcare Provider)**

DATE: _________________________________ School:______________________

FROM: ________________________________________________________________________
(Printed Name of Healthcare Provider and Address)

I hereby acknowledge that my patient, ______________________________________________,
(Name of Student)

has a potentially life threatening condition which is ______________________________________

________________________________________, and **<u>has been instructed in the proper use</u>**

**<u>and method of self-administration of the following medication</u>:**

___________________________________________ ___________________________
(Name of Medication) (Dose)

Method of Administration __________________________________________________________

When to be Administered __________________________________________________________

I further certify that my patient, ____________________, <u>is capable of when and how to self-administer</u> the above medication.

I recognize this permission is effective for the 20__ – 20___ school year and **must be renewed annually** for each subsequent year.

Additional instruction(s), if any:
________________________________________________________________________________

________________________________________________________________________________

_______________________________ __________________________________________
Name of Healthcare Provider (print) (Signature of Healthcare Provider)

Date: __________________________ Witnessed by: _____________________________

(Signature of Parent)