EDISON BOARD OF EDUCATION
EDISON, NEW JERSEY 08837
HEALTH SERVICES

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

School: _____ School Year: _____

Grade/Level: _____ Homeroom: _____

1. We/I (Circle), the undersigned parents(s)/guardian(s) (Circle) of

   _____, authorize the Edison Board of Education to permit
   (Name of Student)
   _____ to carry on his/her person and self-administer his/her
   (Name of Student)

   own medication identified as follows:

   _____
   (Name of Medication)

2. Attached hereto is the written certification of _____, the healthcare provider for the child noted above, that the child has asthma, allergies or another potentially life-threatening illness and is capable of and has been instructed in the proper method of self-administration of the medication identified above.

3. I/We **(Circle)** acknowledge that the Edison School District shall incur no liability as a result of any injury arising from the self-administration of medication(s) by the child noted above and I/We **(Circle)** shall identify and hold harmless the Edison School District and its employees or agents against any claims arising out of the self-administration of medication by the child noted above.

4. This authorization is effective for the 20__ - 20__ school year.

   _____ _____
   (Print name of parent/guardian) **(Print name of parent/guardian)**

   _____ _____
   (Signature of parent/guardian) **(Signature of parent/guardian)**

   _____
   (Date)

5. I take responsibility for proper use and safe handling of my medication. I understand that improper or unsafe use or handling of medication may revoke my self-administration privileges.

   Student signature: _____

Student is responsible for safe and appropriate self-administration of medication. Medication self-administration may be denied if safety is compromised.