RANDOLPH TOWNSHIP SCHOOLS
RANDOLPH, NEW JERSEY

Physician Certification for Self-Medication Pursuant to N.J.S.A. 18A:40-12.3

Name of Student: ________________________________ School: ________________

Teacher: ____ Grade: ________________

Name and Address of Parents/Guardians:

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Medical Condition: ____

Medication/Dosage: ____

Possible Side Effects: ____

I certify that ______________________________suffers from __________________, a

(student) (condition)

Potentially life-threatening illness. I have discussed the administration of this medication with the above-named student and I certify that he/she is capable of and has been instructed in the proper method of self-administration of the medication in an emergency situation as directed above.

_______________________________________ _______________________________

Physician's Signature Date

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Physician's Name (please print)

Parent Acknowledgment and Authorization Pursuant to N.J.S.A. 18A:40-12.3

I hereby authorize the above-named student to self-administer medication in potentially life threatening situations as evidenced by my submission of the above Physician Certification.

By also signing the Acknowledgment, I understand that the Board of Education, its employees or agents shall incur no liability, as a result of any injury arising from the self-administration or medication of the student. I hereby indemnify and hold harmless the Board and its offices, employees and agents against any claims arising out of the self-administration of medication by the student.

_______________________________________ _______________________________

Parent or Guardian Signature Date

_______________________________________ _______________________________

Parent/s or Guardian's Name (please print) Student's Name (please print)