PEQUANNOCK TOWNSHIP PUBLIC SCHOOLS
HEALTH OFFICE

AUTHORIZATION FOR STUDENT SELF-ADMINSTRATION OF MEDICATION

Dear Parent/Guardian,

You have indicated your child has a **LIFE-THREATING CONDITION** and requested that he/she be permitted to carry and self-administer required medication.

Pursuant to NJA.A.C. 6:29-3.2, and PequannockTownship Board Policy 5141.21, you are advised that the District shall not incur liability as a result of any injury arising from the self-medication.

I,_____, parent/guardian of _____
(Print Parents/Guardians Name) (Print Child's Name)

request that he/she be permitted to self-medicate _____
(Prescription**)**
for _____, and understand that the District cannot be held liable for
(Condition)

any injury incurring from this self- medication.

_____ _____
(Date) (Parent/Guardian Signature)

Please have your physician complete the next section:

I certify that the above student, my patient, has the potentially life-threatening condition indicated and in capable of, and has been instructed in the proper administration of the required medication

_____ _____
(Print Name) (Signature)

_____ _____
(Address) (Date)

_____

_____
(Phone number)

REV 6/03