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 Parent(s)/Guardian(s):

_____

_____

_____

Medical Condition: _____

Medication/Dosage: _____

Possible Side Effects: _____

I certify that _____ has asthma or other potentially life-
(student)

threatening illnesses, is subject to a life-threatening allergic reaction, or has adrenal insufficiency. 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

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 by 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's or Guardian's Signature Date

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