CHESTER BOARD OF EDUCATION **FILE CODE: 5141.21**
Chester, New Jersey

Form

SELF-MEDICATION PERMISSION FORM

Student Name_____ Date of birth_____

Name of School_____

Effective for school year_____

PHYSICIAN CERTIFICATION

I certify that the above named student has asthma, diabetes, or anaphylactic reaction.

DIAGNOSIS_____

MEDICATION TO BE SELF-ADMINISTERED_____

DOSAGE_____
FREQUENCY_____

LENGTH OF TIME _____ (not to exceed end of current school year)
I certify that the above-named student is capable of and has been instructed in the proper method of self-administration of the medication prescribed above.

PHYSICIAN NAME (Print) _____ PHONE #_____

PHYSICIAN NAME SIGNATURE_____
DATE_____

PARENT/GUARDIAN PERMISSION

As the parent/guardian of the above-named student, I hereby give permission for my child to self-administer his/her medication as prescribed by the above - signed physician.

PARENT/GUARDIAN NAME (Print) _____

PARENTIGUARDIAN SIGNATURE_____ DATE_____

RELEASE

I, the parent/guardian of _____, have previously advised the _____Board of Education that my child has _____. This illness/condition does require that he/she take medication. My son/daughter is capable of administering the above- prescribed medication and has been instructed in the proper method of taking the medication by himself/herself.

I hereby authorize the _____ Board of Education to allow my child to self-administer this medication.

Reviewed: April 27, 2009, August 2016, September 2018, August 2021

ADMINISTERING MEDICATION (continued)

Representatives of the board of education have advised me that the board shall not be responsible for any liability or resulting injury to my son/daughter arising from the self-administration of medication. I hereby agree to indemnify and hold harmless the Paulsboro Board of Education, its agents, servants and/or employees from any liability relating to or resulting from the self-administration of medication by my child.

Parent Signature_____ Date_____