Sussex-Wantage Regional School District
27 Bank Street, Sussex, NJ 07461

REQUEST FORM FOR STUDENT SELF-MEDICATION

PART I - TO BE COMPLETED BY THE FAMILY PHYSICIAN

STUDENTS NAME:_____

GRADE/SCHOOL:_____

NAME OF MEDICATION:_____

PURPOSE OF MEDICATION:_____

DOSAGE/TIME TO BE GIVEN:_____

DURATION:_____

I certify that _____ has a potentially life threatening illness. This child is being treated by me for_____
_____
and that the medication can be self-administered. Furthermore, the student is capable of and has been instructed in the proper method of self-administration of the medication.

_____
SIGNATURE OF PHYSICIAN DATE

PART II - TO BE COMPLETED BY PARENT/GUARDIAN

I request permission for my child _____ to self-administer the above mentioned medication as per permission of my family physician.

If permission is granted by the school nurse and principal; the school district, the Board of Education and its employees shall incur no liability as a result of any injury arising from the self-medication by my child.

_____
SIGNATURE OF PARENT/GUARDIAN DATE