THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

PARENTAL PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

Student _____ DOB_____ Age _____ Grade _____

I, the parent of _____ give permission for my child to self-
(student's name)
medicate for asthma or other potentially life-threatening illness for the school year.

Signed: _____ Date: _____
Parent's/Guardian's Signature

MEDICATION WAIVER

Student _____ DOB_____ Age _____ Grade _____

This acknowledges that the district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication.

Signed: _____ Date: _____
Parent's/Guardian's Signature

1/05

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PHYSICIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

The following sections are to be completed by the student's physician

Section I

Name of Student _____

Birth Date _____ **School** _____ **Grade** ____

I certify that the above-named student has a potentially life-threatening illness and is capable of, and has been instructed in, the proper method of self-administration of the medication(s) listed below:

Physician's Signature _____ Date _____

Section II

A. Diagnosis for which medication (s) is/are taken _____
_____

B.

	Medication	Dosage	Frequency	Major Side Effects
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

C. How long has student been taking above medications?

1. _____

2. _____

D. Other information or comments about student or medication:

_____

_____

Physician's Signature _____ Date _____

Physician's Name _____ Telephone _____

1/05