

**2026-2027 PHYSICIAN/PARENT CERTIFICATION FOR
STUDENT'S SELF-ADMINISTRATION OF MEDICATION**

CERTIFICATION TO BE COMPLETED BY PHYSICIAN

STUDENT NAME: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

TIME AND CIRCUMSTANCES OF ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS: _____

I certify that _____ has a potentially life threatening illness
(Student)
which requires the use of _____. I further certify that
(Medication)
_____ is capable and has been instructed in the proper method of
(Student)
self-administration of _____
(Medication)

Signature of Physician

Date

PHYSICIAN NAME: _____ TELEPHONE #: _____

CERTIFICATION TO BE COMPLETED BY PARENT

I hereby authorize my son/daughter _____ to self-administer (Name
of Medication) _____ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-
administration of medication by (student name) _____.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising
out of the self-administration of (medication) _____ by
(student name) _____.

Parent/Guardian Signature

Date

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially
life threatening illness is allowed under guidelines established by the school and provided that the statutory
requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A
RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY
A STUDENT.

Rev: 4/2015