Ocean Township High School

Rebecca Sorrentino, MSN, RN, CPN, CSN
School Nurse
732-531-5650 x 1011
732-531-8472 Fax

SPARTAN MISSION:
Meeting the needs of all students with a proud tradition of academic excellence.

PERMISSION TO SELF-ADMINISTER MEDICATION FORM

Physician's Certification (must be renewed each school year)

I _____certify that my patient
Print Physician's Name

_____suffers from_____
Print Student's Name *Print Name of Illness*

A potentially life threatening illness. This student has been instructed in the proper method of self-medication for this illness and is capable and responsible to administer

_____ _____
Print Name of Medication *Dosage*

_____ _____
Print Frequency of Medication *Period of Administration*

Contraindications for administration would be _____

Possible Side Effects _____

This Student is free of contagious disease and is physically able to attend school. This pupil would not be able to attend school if the medication is not administered during school hours.

_____
Physician Signature *Telephone #* *Date*

Parental Authorization:
As Parent/Guardian of_____, I request permission for my child to carry and use the above prescribed medication while on School Property or at an approved school event.
I hereby agree to indemnify and hold harmless the Board of Education of the Township of Ocean School District and it's employees from any and all losses, claims, injuries, damages or expenses that arise out of self medication.

_____ _____
Parent's Signature *Date*

Home of the Spartans!
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