

ROXBURY TOWNSHIP SCHOOLS

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION  
FOR POTENTIALLY LIFE-THREATENING ILLNESSES

NAME \_\_\_\_\_ DATE \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

GUIDELINES FOR ADMINISTRATION \_\_\_\_\_  
(Please be specific)

I certify \_\_\_\_\_ suffers from  
(student's name)  
a potentially life-threatening illness \_\_\_\_\_  
(condition)  
and is capable of, and has been instructed in, the proper method of  
self-administration of the above stated medication.

\_\_\_\_\_  
Physician's Printed Name Physician's Signature Date

To be completed by the parent/guardian:

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

I give permission for \_\_\_\_\_  
(student's name)  
to self-administer \_\_\_\_\_  
(medication)  
as prescribed by his/her private physician.

\_\_\_\_\_  
Parent/Guardian Printed Name Parent/Guardian Signature Date

This permission form is effective only for the school year for which it is granted and must be renewed each school year.