Roxbury Township Schools

Permission for Self-Administration of Medication
For Potentially Life-Threatening Illness

Name______________________________ Date____________

School________________________________________ Grade________

Medication_____________________________________________________________

Dosage_______________________________________________________________

Guidelines for Administration_______________________________________________
(Please be Specific)

______________________________________________________________________
______________________________________________________________________

I certify _____________________________________________________ suffers from
(Students 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 and Stamp     Date

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To be completed by the parent/guardian:

I acknowledge that the Boards 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___________________________________________________ as prescribed
by his/her physician. (medication)

_________________________     __________________________     _______________
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.