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)

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____

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.