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-admnistration 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.