2024-2025 PHYSICIAN/PARENT CERTIFICATION FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION

CERTIFICATION TO BE COMPLETED BY PHYSICIAN

STUDENT NAME: _____

DIAGNOSIS: _____

NAME OF MEDICATION _____

DOSAGE: _____

TIME/CIRCUMSTANCES FOR ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS: _____

I certify that _____ has a potentially life-threatening illness.

Which requires the use of (Medication) _____.

I further certify that above named student is capable and has been instructed in the proper method of self-administration of the above-named medication.

_____ _____

Signature of Physician Date

Physician Name _____ Telephone #_____

CERTIFICATION TO BE COMPLETED BY PARENT

I hereby authorize my son/daughter to self-administer (Name of Medication) _____ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-administration of medication by (student name) _____

I shall indemnify and hold harmless the school, its employees, and agents against all claims arising out of the self-administration of medication.

Parent/Guardian Signature_____Date_____

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially life-threatening illness is allowed under guidelines established by the school and provided that the statutory requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF IWDICATION BY A STUDENT. Rev: 4/2015