Parent/Guardian Authorization for Self-Administration of Medication by Child

SECTION I: To be completed by parent/guardian

I _____ authorize the Winslow Township School District to permit
(Name of Parent/Guardian)

my child _____ to self-administer medication which
(Name of Child)
has been prescribed by the physician named below.

I attest that the need for my child's self-administration of medication is due to a potentially life-threatening illness. I further attest that my child has been instructed in the proper methods of self-administration of medication.

I understand and fully agree that the Winslow Township School District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child or ward. I further indemnify and hold harmless the school district, its employees or agents against any claims arising out of self-administration of medication by my child or ward.

I further agree that the authorizations and acknowledgments made herein are effective for a full school year beginning September 1 through June 30 and said authorization shall also include the months of July and August following that school year if my child attends a district summer school. I also understand and agree that permission must be authorized each and every succeeding school year through the completion of a new authorization form including a renewed physician's a physician's acknowledgment.

_____ Date_____
Signature of Parent or Guardian

For school year beginning:_____

SECTION II: To be completed by the Family Physician

As physician for _____ I herein certify that this child has a
(Name of child)

potentially life-threatening condition which is _____ and this condition necessitates that he/she be permitted to self-administer a prescribed medication, while in school or while attending a school sponsored trip or function.

This medication is: _____ Normal Dosage/Frequency _____

Route of Administration:_____ Special Instructions:_____

Precautions/Side Effects:_____

I attest that the child has been instructed in the proper method(s) of self-administration of the above prescribed medication and is capable of doing same in a safe and appropriate manner.

_____ Date:_____
Signature of Physician

_____ Telephone:_____
Print name of Physician

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