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Rahway Public Schools

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Self-Administration of Medication

Student: ____ DOB: ____________________

School: ____ Grade: ____________________

Date: ____________________ School Year: ____________________

Physician Certification

I certify that ___________________________ has the following potentially life threatening illness:
(Student's name)
_______________________________, has been instructed in the proper method of self-administration of this medication and is capable of independently following those instructions.

1. __________________________/____________________/ ____________________
(Name of Medication) (Dosage) (Route)

Time of administration: ____________________

2. __________________________/____________________/ ____________________
(Name of Medication) (Dosage) (Route)

Time of administration: ____________________

_____________________________ _______________________________ ____________
(Physician's name) (Physician's Signature) (Date)

Parent/Guardian Certification

I give my child, ____, permission to self-administer
(Student's name)

1. __________________________ 2. __________________________
(Name of Medication) (Name of Medication)

as instructed by the physician certification above, both on school premises during regular school and off-site or after school when he/she is participating in field trips or extracurricular activities.

The school district shall incur no liability as a result of any injury arising from the self-administration of the medication and the parents/guardians, named below, shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administrations of medication by the student.

_____________________________ _______________________________ ____________
(Parent/Guardian Name) (Parent/Guardian Signature) (Date)

School District Certification

Based on the above physician and parent certifications, ___________________________ is authorized to self-administer:
(Student's name)

1. ___________________________
(Name of Medication)

2. ___________________________
(Name of Medication)

as instructed by the physician certification above, both on school premises during regular school hours and off-site or after school when he/she is participating in field trips or extracurricular activities during current school year. This permission must be renewed annually.

The school district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of the medication. The school nurse, principal, or Supervisor of Services for Children, in consultation with the school physician and acting as agents of the Board, reserve the right to revoke this permission if the pupil does not comply with the established self-medication procedures.

_____________________________ _______________________________ ____________
(School Nurse Name) (School Nurse Signature) (Date)

One copy of this completed form shall be kept on file by the school nurse assigned to the pupil's school and one copy shall be provided to the parents.