

WHITE TOWNSHIP CONSOLIDATED SCHOOL
565 County Road 519
Belvidere, NJ 07823
Phone: (908) 475-4773
Fax: (908) 475-3627

SELF-MEDICATION RELEASE FORM

SCHOOL YEAR _____

PHYSICIAN AUTHORIZATION:

This is to verify that _____ is under my care for _____ and
Student condition
is capable of, and instructed in the proper method of self-administration of the medication

_____. This student is responsible to carry the medication on his/her person.
Name of medication

Physician Signature/Stamp

Date

PARENT/GUARDIAN AUTHORIZATION:

This is to authorize the self authorization of medication for _____.
Student

I understand the White Township Board of Education, its employees or agents shall incur no liability from the self-administration of medication by the pupil. We, the parents/guardians shall indemnify and hold harmless the White Township Board of Education, its employees or agents against any claims arising out of self-administration of medication by the pupil.

We also understand this permission is effective for the current school year only.

Parent/Guardian Signature

Date

** Please note this form is for "potentially life threatening illnesses" only, such as bee sting allergy, asthma, diabetes and cystic fibrosis. No other medications are permitted to be carried and self-administered by students.