PAULSBORO BOARD OF EDUCATION **FILE CODE: 5141.21**
Paulsboro, New Jersey

Form

Addendum #2

Paulsboro Public Schools
Paulsboro, NJ
SELF-MEDICATION PERMISSION FORM

Student Name_____ Date of birth_____

Name of School_____

Effective for school year_____

PHYSICIAN CERTIFICATION

I certify that the above named student has asthma, diabetes, or anaphylactic reaction to insect bites.

DIAGNOSIS_____

MEDICATION TO BE SELF-ADMINISTERED_____

DOSAGE_____ FREQUENCY_____

LENGTH OF TIME _____(not to exceed end of current school year)
I certify that the above-named student is capable of and has been instructed in the proper method of self-administration of the medication prescribed above.

PHYSICIAN NAME (Print)_____ PHONE #_____

PHYSICIAN NAME SIGNATURE_____ DATE_____

PARENT/GUARDIAN PERMISSION

As the parent/guardian of the above-named student, I hereby give permission for my child to self-administer his/her medication as prescribed by the above - signed physician.

PARENT/GUARDIAN NAME (Print)_____

PARENTIGUARDIAN SIGNATURE_____ DATE_____

RELEASE

I, the parent/guardian of _____, have previously advised the Paulsboro Board of Education that my child has _____ . This illness/condition does require that he/she take medication. My son/daughter is capable of administering the above- prescribed medication and has been instructed in the proper method of taking the medication by himself/herself.

I hereby authorize the Paulsboro Board of Education to allow my child to self-administer this medication. Representatives of the Board of Education have advised me that the Board shall not be responsible for any liability or resulting injury to my son/daughter arising from the self-administration of medication. I hereby agree to indemnify and hold harmless the Paulsboro Board of Education, its agents, servants and/or employees from any liability relating to or resulting from the self-administration of medication by my child.

Parent Signature_____ Date_____