NEW ROAD SCHOOL

Of Ocean County

810 TOWBIN AVENUE
LAKEWOOD, NEW JERSEY 08701-5928
TEL: (732) 886-6888 FAX: (732) 886-6990

Dear Parent/Guardians,

This form is required when a student is responsible for administering any self-medication, for example, a student using an inhaler for asthma. The intent of this form is to reinforce the proper administration to promote the well being of the student and prevent further difficulties.

If you have any questions please feel free to contact me.

Thank you for your assistance.

School Nurse

2016 Extended School Year Program **2016 - 2017 School Year** **Date:_____**

SELF-ADMINISTRATION OF MEDICATION

(**BOTH** parent and physician MUST complete prior to a student administering any self-medication)

PARENTAL AUTHORIZATION:

I, _____ hereby authorize my child, _____; to self-administer medication for the illness certified by his/her physician below for the **2016** extended school year and **2016 – 2017** school year. I understand that the New Road School is held harmless against any injury or claims that arise as a result of my child's self administration.

_____ _____
Signature of Parent Date

PHYSICIANS CERTIFICATION:

_____ Extended School Year Program _____ School Year Date:_____

I certify that _____ is capable of and has been instructed in the proper administration of the required medication.

_____ _____
Signature of Physician Date

_____ _____
Diagnosis Medication