Tabernacle School District

PARENT/GUARDIAN AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION

Student Name________________________ **Grade/Homeroom**__________________

1. I, the undersigned parent of the above named student, authorize the Tabernacle School District to permit my child to carry on his/her person and self administer his/her own medication(s) as follows:

____

Name of Medication(s)

2. _________________________ has completed and I have submitted to the school nurse an
(Name of Healthcare Provider)
Asthma Action Plan as written certification that my child has asthma, a potentially life threatening illness. My child has been instructed in, and is capable of the proper method of self administration of the medication(s) listed above.

3. I am aware that my child will be expected to report use of his/her medication to the nearest staff member of Tabernacle School District as soon as possible after use. The staff member will assist my child in notifying the school nurse of all non-routine medication use. ____________ **(initial)**

4. I acknowledge that the Tabernacle School District shall incur no liability as a result of any injury arising from the self administration of medication by my child. If procedures specified by NJ law and Tabernacle School District policy are followed, I shall indemnify and hold harmless the Tabernacle School District and it's employees or agents against any claims arising out of self administration of medication of the child noted above. This authorization is effective for the 20___-20____school year.

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Printed name of parent/guardian

_______________________________________ _______________________
Signature of parent/guardian **Date**

5. I take responsibility for the proper use and safe handling of my medication. I will report to a staff member as soon as possible after each use of my medication. I understand that improper or unsafe use and/or handling of medication may result in loss of self administration privileges.

Student Signature:_____________________________ **Date**:________________________

School use only

________________________________ _______________
Signature of Principal **Date**

________________________________ _______________
Signature of School Nurse **Date**