CRESSKILL PUBLIC SCHOOLS

PHYSICIAN'S ORDER AND PARENT AUTHORIZATION FOR STUDENT SELF-ADMINISTERED MEDICATION FOR A LIFE-THREATENING CONDITION

I. PHYSICIAN'S ORDER

STUDENT'S NAME:_____

DATE OF BIRTH:_____ GRADE:_____

ADDRESS: _____

ALLERGIES: _____

DIAGNOSIS:_____

MEDICATION:_____

REASON(S) FOR MEDICATION:_____

_____

DOSAGE:_____

POSSIBLE SIDE EFFECTS:_____

_____

OTHER DIRECTIONS:_____

Is student physically fit to attend school and free of contagious disease?

Yes ____ No _____

I certify that this student has asthma or another potentially life-threatening illness, is capable of, and has been instructed in the proper method of self-administration of medication.

PHYSICIAN'S NAME:_____

(Please Print)

ADDRESS:_____

PHONE NO.:_____

PHYSICIAN'S SIGNATURE:_____ DATE:_____

II. PARENTAL/GUARDIAN AUTHORIZATION

The Cresskill Board of Education informs you that the Cresskill Board of Education and its employees, officers, agents and servants shall have no liability as a result of any injury arising from self-administration of medication by this student.

I hereby request and authorize that my child, _____,
(Insert Student's Name)
be permitted to carry and self-administer the aforementioned medication during regular school hours and at other times when my child is participating in a school-related event.

I understand that the Cresskill Board of Education and its employees, officers, agents and servants shall have no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the Cresskill Board of Education and its employees, officers, agents and servants against any claims arising out of the self-administration of medication by my child.

I understand that permission is effective for the school year in which it is granted and must be renewed for each subsequent school year.

_____
PARENT'S/GUARDIAN'S NAME (Please Print)

_____ _____
PARENT'S/GUARDIAN'S SIGNATURE DATE