CRESSKILL PUBLIC SCHOOLS

Self Administration of Medication in School /Field Trips

Date _____ Student's Name_____

Date of Birth _____ Weight_____

Medication _____
Dose_____
Route_____
Time_____

Diagnosis/Reason for Medication _____

Possible Side Effects _____

Any Circumstances when medication should not be given:_____

THIS STUDENT MAY CARRY AND SELF ADMINISTER THIS MEDICATION AND HAS BEEN INSTRUCTED ON HOW TO DO SO.

Physician's Signature_____

Physician's Name:_____
Address_____
Phone_____

The Physician must complete this for ANY medication

PARENTAL AUTHORIZATION

I give permission for my child to carry and self administer this medication according to my physician's instructions. I also verify that I/we have instructed our child in proper use and self administration of the above medication and that he/she has demonstrated that he/she is capable of safe and correct self administration of the above medication. I will notify the school immediately if my child's health status changes or there is a change or cancellation of the medication. The medication is to be provided by me in the original labeled container. To my knowledge, my child is not allergic to this medication. I hereby relieve the Board of Education and its employees of and all liability which may result from administration of this medication to my child.

Parental Signature_____ Date_____