



Parents
Teachers
Children
Community
Administrators

Hopatcong Borough Schools

Dr. Charles Maranzano, Jr.
Superintendent of Schools

2010-2011 School Year

Theresa A. Sierchio
Business Administrator/Board Secretary

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

Permission for self-administration of medication of a pupil with asthma or another potentially life-threatening illness may be granted if all of the following statements are signed by the parent/legal guardian and are submitted to the school Principal. The school Principal will make the final determination to allow or deny the request. The school Principal will consult with the school nurse and the school physician to assist him/her in making that determination.

PARENT(S)/LEGAL GUARDIAN CERTIFICATION

We (I) _____ (parent/legal guardian name(s))
authorize the self- administration of medication (list the specific medication)

by our child _____ (name of pupil) under the following
circumstances _____

We (I) _____ (parent/legal guardian
name(s)) acknowledge that the school district shall incur no liability as a result of any
injury arising from the self-administration of medication by our child
_____ (name of pupil)

We (I) _____ (parent/legal guardian name(s))
indemnify and hold harmless the school district, the Board of Education, and its
employees or agents from any and all claims arising out of the self-administration of
medication by our child _____ (name of pupil)

Parent/Legal Guardian Signature

Date

Witness

Date

Parents/legal guardians **must provide the following signed written certification** from the physician of the pupil that the pupil has asthma or another potentially life threatening illness and is capable of, and has been instructed in, the proper method of self-administration of medications:

PHYSICIAN CERTIFICATION

Pupil's Name: _____

Name of Medication: _____

Purpose of its administration to the pupil for whom the medications is intended:

Timing and Dosage Instructions: _____

Any Possible side effects of the medication: __ (documents may be attached) _____

Time the medication will be discontinued: _____

This pupil is physically fit to attend school and is free of contagious disease.

This pupil would not be able to attend school and/or the Day Plus Program if the medication is not administered during school hours and/or the Day Plus program before and after school hours.

Physician's Signature

Date