



**PHYSICIAN CERTIFICATION
PARENT/LEGAL GUARDIAN PERMISSION
FOR
SELF-ADMINISTRATION OF MEDICATION**

RE: _____
Child's Name _____ Date of Birth _____

PHYSICIAN'S CERTIFICATION

I certify that the above student, who is my patient, suffers from _____, which is a potentially life threatening illness. I further certify that the above student is capable of and has been instructed in the appropriate method of self-administration of medication. I also certify that the above student knows the appropriate dosage, side effects, and the risks involved in taking the medication listed above. This certification is made in accordance with NJSA 18A:40-12.3.

Name of Medication/Time/Dosage

Office Stamp

Physician's Signature

Date

PARENT/LEGAL GUARDIAN PERMISSION

I am the parent/legal guardian of _____. I give permission for my child, _____, to self medicate while attending normal school hours. This includes pre and post school sponsored activities. I/we shall indemnify and hold harmless the Voorhees Township Board of Education, its employees and agents against any claims that arise out of self-medication. I understand that my physician must certify my child's illness and ability to self medicate on an annual basis. I must also provide permission on an annual basis for my child to self medicate.

Parent/Legal Guardian Signature

Date