Franklin Borough School
Health Office
50 Washington Ave.
Franklin, NJ 07416
973-827-9775 ext. 219
Fax 973-827-6522

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Date: _______________

Student Name: ____________________________ DOB _____________ Homeroom _________

Parent/Guardian: ________________________________ Daytime Tele. #: _________________

To be completed by physician (please print):

Identification of medical problem: ____

I am recommending that the above named student be allowed to self-administer the following

medication: ____

Prescribed dosage: ____

Length of time medication must be taken: ____

Possible side effects and/or special precautions to be taken: _____________________________

____

Physician's name (please print) ____________________________________ Date: __________

Signature: ____

Physician's statement:

I certify that this student has had training in the use of this medication and is proficient in self-administering it.

Physician/Trainer: ____ Date: _____________

School Nurse: ____ Date: _____________

To be completed by parent/guardian:

I give my permission for my child to **se**lf-administer the medication prescribed above. The Franklin School District shall incur no liability as a result of any injury arising from the use of the medication described above. I further hold the Franklin School District harmless against any injury claims that arise as a result of the self-medication. I understand that this permission should be renewed annually.

Parent/Guardian Signature: ___________________________________Date: _______________

Please return this form to the School Nurse