Lacey Township School District
OFFICE of the DIRECTOR OF SPECIAL SERVICES
73 Haines Street, Lanoka Harbor, NJ 08734-2115

Phone (609) 971-2000 Fax: (609) 971-5714
www.laceyschools.org

Michael Maschi

SELF-MEDICATION PERMISSION FORM

In accordance with Chapter 308,P.L. 1993, this form must be signed by the parent or legal guardians of any student who wishes to self-administer medication.

We are (I am) the parent or legal guardian of _____, a student in the Lacey Township School District. As required by law this form provides to the Lacey Township Board of Education our (my) written authorization for our (my) child to self-administer medication. We (I) further acknowledge that by copy of this form, that the Lacey Township Board of Education has informed us (me) that the District, its employees or agents, shall incur no liability as a result of any injury from self-administration by our (my) child. Further, by signing this form, we (I) release the Lacey Township Board of Education, its employees or agents from liability as a result of any injury from self-administration of medication by our (my) child and we (I) expressly agree to defend, protect, indemnify, and hold harmless the Lacey Township School District and its employees or agents, from all losses, costs, suits or claims which may result from self-administration of medication by our (my) child.

Included in this form is the written certification of our physician verifying the diagnosis of our (my) child as potentially life-threatening and the provision of medication instructions. Permission for our (my) child to self-administer medication is effective upon approval and notification by the Lacey Township Board of Education. **Permission remains effective only for the current school year.**

_____ _____
Signature of Parent Signature of Parent

_____ _____
Date Telephone

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PHYSICIAN CERTIFICATION FOR SELF MEDICATION BY A STUDENT

In accordance with Chapter 308,P.L.1993, I _____,
(Print name of physician)

certify that I am the physician for _____.
(Print name of student)

This patient suffers from _____,
(Print name of illness)

a potentially life threatening illness, and is capable of and has been instructed in the proper method of self administration of medication for this illness.

NAME OF MEDICATION _____

DOSE/ROUTE _____ TIME _____

ADDITIONAL INSTRUCTIONS _____

SIGNATURE OF PHYSICIAN _____

DATE _____ TELEPHONE _____