

**2019-2020 PHYSICIAN/PARENT CERTIFICATION FOR  
STUDENT'S SELF-ADMINISTRATION OF MEDICATION**

**CERTIFICATION TO BE COMPLETED BY PHYSICIAN**

STUDENT NAME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

TIME AND CIRCUMSTANCES OF ADMINISTRATION: \_\_\_\_\_

POSSIBLE SIDE EFFECTS: \_\_\_\_\_

I certify that \_\_\_\_\_ has a potentially life threatening illness  
(Student)  
which requires the use of \_\_\_\_\_. I further certify that  
(Medication)  
\_\_\_\_\_ is capable and has been instructed in the proper method of  
(Student)  
self-administration of \_\_\_\_\_  
(Medication)

\_\_\_\_\_  
Signature of Physician Date

PHYSICIAN NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

\*\*\*\*\*

**CERTIFICATION TO BE COMPLETED BY PARENT**

I hereby authorize my son/daughter \_\_\_\_\_ to self-administer (Name  
of Medication) \_\_\_\_\_ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-  
administration of medication by (student name) \_\_\_\_\_.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising  
out of the self-administration of (medication) \_\_\_\_\_ by  
(student name) \_\_\_\_\_.

\_\_\_\_\_  
Parent/Guardian Signature Date

**SELF-ADMINISTRATION OF MEDICATION IN SCHOOL**

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially  
life threatening illness is allowed under guidelines established by the school and provided that the statutory  
requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A  
RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY  
A STUDENT.