

Clifton Public Schools
Health Services

Physician's Request for Self-Administration of Medication

Name of student _____ Grade/Homeroom _____

School _____

Name of Medication _____ Dose/Time _____

Reason for Medication _____

Start Date _____ Stop Date _____

Restrictions and/or important side effects: ____ (describe below) None anticipated ____

Please describe: _____

This student is both capable and responsible for self-administering this medication:

____ Yes-unsupervised ____ No

Physician's Signature _____ Date _____

Physician's Name _____ Phone Number _____

Physician's Address _____

Parent's Request for Self-Administration of Medication

I, _____, the parent/guardian of

_____ hereby authorize the self-administration of the above medication. By signing this acknowledgement, I understand that the Clifton Board of Education, its employees or agent shall incur no liability as a result of any injury arising from the self-administration of medication by my child, and that I hereby indemnify and hold harmless the Clifton Board of Education, its employees or agents against any claims arising out of the self-administration of medication by my child.

Parent's/ Guardian's Signature Date

Date _____ Approved by School Physician _____