



OGDENSBURG BOROUGH BOARD OF EDUCATION
100 Main Street Ogdensburg, NJ 07439

Dave Astor
Superintendent/Principal

Skye Patete
Vice Principal

Richard Rennie
Business Administrator/Board Secretary



Self Administration Medication Form
Inhalers, Epinephrine Autoinjectors Only

Student's Name _____ Date _____

Parent/Guardian Name _____

Telephone #: Home: _____ Work _____

Cell _____

Physician's Section

Identification of Chronic Medical Problem: _____

Rx: _____

Dosage to be given: _____

Length of time/frequency medication to be taken: _____

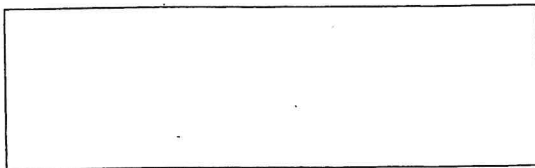
Possible side effects and/or special precautions to be taken: _____

Conditions under which self-administration will take place:

Child must have had training and be proficient in self-administration of medication. The physician completing this form **certifies that training has taken place.**

Medication should be _____ stored in the Nurse's office
_____ in the possession of the student

PRINT Physician's Name



Physician's Stamp

Physician's Signature

Telephone number

Date

SEE OTHER SIDE

Parent/Guardian Section:

1. I give my permission for my child to self-administer the medication prescribed. I will notify the School Nurse in writing if the medication is no longer required or if self-administration is no longer directed by the physician. I understand this form is in effect for the current school year from September to June and must be renewed each year.
2. I understand that the district shall incur NO liability as a result of any injury arising from the administration of medication by the designated person.
3. I indemnify and hold harmless the district and any employees or agents against any claims arising out of the administration of medication by the designated person.

Parent/Guardian Signature
