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, Epinepherine 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 givien:_____

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 Signature

_____
Telephone number

_____
Date

Physician's Stamp

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

_____