

TOWNSHIP OF UNION PUBLIC SCHOOLS
PHYSICIAN'S CERTIFICATION FOR SELF-ADMINISTRATION
OF MEDICATION IN SCHOOL

Student's Name: _____ Date: _____

School: _____ Grade: _____

Physician's Name: _____ Phone: _____

Physician's Address: _____

I request that the above student be allowed to self-administer his/her medication(s) in school. I hereby certify that he/she suffers from asthma or another potentially life-threatening illness, which requires immediate use of medication self-administered by the student. I also certify that he/she has been trained in the proper method and use of the medication and its administration and is capable on self-administration of the medication. The student should be allowed to carry his/her medication during regular school hours and off-site or after regular school hours when he/she is participating in field trips or extracurricular activities.

Permission is effective for the school year for which it is granted and must be renewed for each subsequent school year by resubmission of this form properly completed.

Diagnosis: _____

Name of medication: _____

Time or circumstance under which medication shall be administered: _____

Dosage: _____

Possible side effects: _____

Special instructions: _____

Physician's signature: _____

WAIVER OF LIABILITY

I/we are the parent(s)/guardian(s) of _____, a pupil in the Union Public Schools. I/we hereby authorize _____ to self-administer medication as directed by his/her physician. I/we understand and acknowledge that neither the Union Township Board of Education, its employees or agents shall incur liability as a result of any injury arising from the self-administration of medication by the pupil named above. In addition, I/we agree to indemnify, defend and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by the pupil. I/we hereby acknowledge having been properly informed that the District, its employees or agents shall incur no liability as a result of any claim, injury or damages arising from the self-administration of medication by the pupil named above. Furthermore, I/we agree to comply with any current or subsequent rules promulgated by the Board of Education or the State Department of Education concerning this matter.

Date: _____

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____