FAIRFIELD PUBLIC SCHOOLS
FAIRFIELD, NEW JERSEY 07004

PHYSICIAN CERTIFICATION FOR SELf- MEDICATION
PURSUANT TO N.J.S.A. 18A:40-12.3

Name of student:_____

Name of Parents/Guardians:_____

Address of Parent/Guardians:_____

Name of Physician:_____

Address of Physician:_____

_____

Type of Illness:_____

Medication:_____Dosage:_____

Frequency given:_____

Directions for administration:_____

_____

Purpose of medication:_____

Possible side effects:_____

The Physician has discussed the administration of this medication with the above named student and certifies that he/she is capable of and has been instructed in the proper method of self-administration of the medication in an emergency situation as directed above.

_____ _____
Physician's Signature Date

_____

PARENT ACKNOWLEDGEMENT AND AUTHORIZATION
PURSUANT TO N.J.S.A. 18A:40-12.3.

The Parents/Guardians, hereby authorize the above named child to self-administer the medication as identified above pursuant to N.J.S.A. 18A:40-12.3.

By also signing this Acknowledgement, we understand that the Board, its employees or agents shall incur no liability as a result of any injury arising from the self-administration or medication of the pupil, and that we hereby indemnify and hold harmless the Board, its employees or agents against any claims arising out of the self-administration of medication by the pupil.

_____ _____
Parent/Guardian Signature Date