Work Delaware Township School
PO Box 1000 – Sergeantsville, NJ 08557
Phone (609) 397-3179 Fax (609) 397-1485

Self-Medication Dispensing Form

(Inhalers & Epi-pens)

Student's Name _____ Age _____ Grade _____

Reason for Medication _____

Medication/Dosage _____

Times to be Administered _____

Possible Side Effects _____

Effective Dates: From _____ To _____

I certify that this student suffers from asthma or other potentially life-threatening illness and is capable of, and has been instructed in the proper method of self-administration of this medication.

I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment.

_____ _____
Physician's Signature Date

_____ _____
Address Telephone Number

As parent/guardian of the above named child, I hereby request that my child be permitted to carry and self-administer the medication described above as provided in A 2600 and signed into law on December 23, 1993. I further certify that I will indemnify and hold the Delaware Township District and its employees harmless against any injury or claims that arise as a result of this self-administration.

_____ _____
Parent Signature Home Telephone Number

_____
Work Telephone Number