

SOUTH ORANGE-MAPLEWOOD BOARD OF EDUCATION
Request for Administration of Medication

To be completed by the parent/guardian:

Student's Name Date of Birth School

I/We hereby request that the above-named student be granted permission for the administration of medication at school and at school sponsored events.

I/We acknowledge that the school district shall incur no liability as a result of any injury arising from the administration of medication to our child, and we hereby indemnify and hold harmless the school district, and its servants, agents and employees, against any claims, fees or costs, including attorneys fees, which may arise from the administration of medication to our child.

We understand that permission to administer medication is effective for the school year for which it is granted and must be renewed annually.

(Print)Parent/Guardian's Name Parent/Guardian's Signature

Date

To be completed by the student's physician:

I hereby certify that I have diagnosed the above-named student with _____ and I have prescribed the following medication. The student is physically fit to attend school and is free of contagious disease. The student would not be able to attend school if the medication noted above were not administered during school hours or at school sponsored events.

Name of medication: _____

Purpose of medication: _____

Proper timing and dosage of medication: _____

Possible side effects of medication: _____

Date when the medication shall be discontinued/expired: _____

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Physician's Name Physician's Signature Date

APPROVED BY:

School Principal's Signature Date