Saint Rose of Lima Academy
52 Short Hills Avenue
Short Hill, New Jersey 07078

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

(TO BE KEPT CONFIDENTIAL UPON COMPLETTION)

NAME OF STUDENT_____GRADE_____

DIAGNOSIS_____

MEDICATION_____

DOSAGE_____

FREQUENCY_____

SPECIAL DIRECTIONS_____

POSSIBLE SIDE EFFECTS_____

I certify that the above information regarding this student is correct, that administration of the medication to this Student is necessary, and that the Student has received appropriate instruction to self-administer the medication.

_____ _____
Signature of Prescribing Physician **Date**

_____ _____
Address **Phone**

I/We authorize the Principal and the School Nurse to permit the Student to self-administer the above medication as indicated. I/We understand and agree that the school, the school Nurse and the Principal shall not be liable for any injury to the Student resulting from the self-administration of the medication as authorized by my signature below.

_____
Signature of Parent/Guardian

_____
Signature of Parent/Guardian

_____
Date