JACKSON SCHOOL DISTRICT

151 Don Connor Blvd.
Jackson, NJ 08527

(732) 833-4600

Student: ______________________ Grade: _________________

Authorization for Self-Administration of Medication

I, ______________________________ of ____________________________,
Parent or Guardian (circle one) Name of Student

a student at the ______________________School, hereby authorize the Jackson Township Board of Education and its employees to permit ___________ to self-
Name of Student

administer medication for ________________________.
Name of Illness

I enclose a written certification from Dr. ___________________ that _____________
Name of Student

Suffers from a potentially life-threatening illness and that he/she is **capable** of, and has been instructed in, the proper method of self-administration of medication. I hereby acknowledge the Jackson Township Board of Education, its agents and employees shall incur no liability as a result of any injury arising from the self-administration of medication by _________________. I also agree to indemnify and hold harmless the
Name of Student

district and its employees or agents against any claims arising out of self-administration of medication by __________________________.
Name of Student

________________________________ ________________
Signature of Parent or Guardian Date

Rev 2/07