THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

PARENTAL PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

Student _____ DOB_____ Age _____ Grade _____

I, the parent of _____ give permission for my child to self-
(student's name)
medicate for asthma or other potentially life-threatening illness for the school year.

Signed: _____ Date: _____
Parent's/Guardian's Signature

MEDICATION WAIVER

Student _____ DOB_____ Age _____ Grade _____

This acknowledges that the district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication.

Signed: _____ Date: _____
Parent's/Guardian's Signature