Bloomfield Public Schools

155 Broad Street, Bloomfield, New Jersey 07003

HEALTH SERVICE
Self-administration form

I authorize that _____ GR/HR _____a pupil
In the Bloomfield Public Schools, is capable of and has been instructed to carry and self-administer medication without medical supervision of the school nurse. This medication may be required from time to time for the treatment of _____, a potentially life threatening illness.

_____(Student's Name), has been instructed and made fully aware of the following:

1. Instruction in proper method for self-administration.
2. The medication is for his/her use only.
3. After self-administering medication in school or at school activities, the student must report to the school nurse, coach, or teacher immediately.
4. I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.

Additionally, I accept full responsibility for any reaction or condition which may occur due to the above. Furthermore, I exonerate the Bloomfield Board of Education, their employees and agents, from any claims arising out of self-administration of medication by the pupil associated with the above.

TO BE COMPLETED BY PHYSICIAN

Name of Medication_____

Frequency _____ Dosage_____

Duration_____

Possible side effects (list or attach info.): _____

_____

_____

Primary Physician's Signature/Address:_____Date:_____

Parent/Guardian Signature:_____ Date:_____

School Physician's Signature:_____ Date:_____

Principal's Signature:_____ Date:_____