

**TOWNSHIP OF OCEAN INTERMEDIATE SCHOOL
PERMISSION TO SELF- ADMINISTER INHALER-INSULIN FORM
FAX- 732-531-6561**

A. Physician's Certification(Must be renewed each school year)

I _____ certify that my patient _____
Print Physicians name Print Students name
suffers from _____
a potentially life threatening illness. This student has been instructed in the Proper method of self-medication for
this illness and is capable and responsible to administer.

_____ Dosage
Print name of medication

_____ Period of Administration
Print frequency

Contraindications for administration would be: _____

Possible side effects: _____

This student is free of contagious disease and is physically able to attend school. This pupil would not be able to attend school if the medication is not Administered during school hours.

_____ Telephone _____ Date _____
Physicians signature

B. Parental Authorization

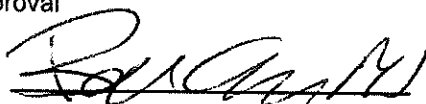
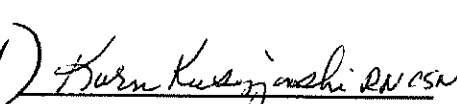

As a Parent/Guardian of _____, I request permission for my child to carry and use the above prescribed medications while on school property or at an approved school event.

I hereby agree to indemnify and hold harmless the Board of Education of the Township of Ocean School District and it's employees from any and all losses,claims, injuries, damages or expenses that arise out of self medication.

I also agree to provide an additional identical medication to the school nurse to be retained in her office according to school policy.

_____ Date _____ Grade _____
Parent's signature

C. Approval

  
School Physician's Signature School Nurse's Signature Building Principal's Signature