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.

_____ _____
Print name of medication Dosage

_____ _____
Print frequency Period of Administration

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.

_____ _____ _____
Physicians signature Telephone Date

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.

_____ _____ _____
Parent's signature Date Grade

C. Approval

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