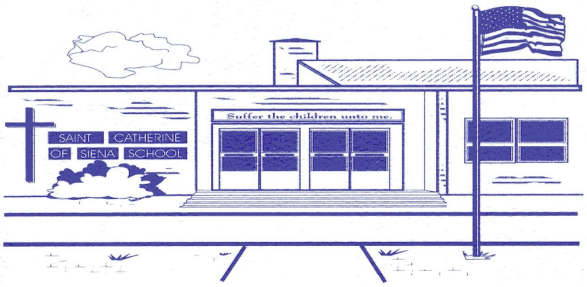


**ST. CATHERINE OF SIENA SCHOOL**
*Middle States Accredited*
39 E. Bradford Avenue, Cedar Grove, NJ 07009
Telephone 973-239-6968 Fax 973-239-1008
www.scs-school-cedargrovenj.org

## AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student _____ Grade: _____

Diagnosis/Illness _____

Medication _____

Dosage_____ Frequency _____

Special Directions _____

Possible Side Effects _____

I certify that the above information regarding this student is correct, that administration of the medication to this student is necessary, and that the student has received appropriate instruction to self-administer the medication in school.

_____ _____
Signature of Prescribing Physician Date

_____ _____
Address Phone

**Parent/Caregiver Permission for Self-Administration of Asthma Inhalers & Medication for Life Threatening Illness**

**To be completed by Parent/Caregiver:** I give permission for my child to self-administer EpiPen/Twinject, Benadryl or "rescue inhaler" medication. I will notify the school nurse immediately if this medication is no longer directed by the physician.

I understand and agree that the school shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall indemnify and hold harmless the school and its employees or agents against any claims arising out of the self-administration of medication by the pupil.

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 school.

_____ _____ Parent/Caregiver
Signature Date

**Student Agreement for Self-Administration**

**To be completed by the student:** I understand that I will use this medication as directed by my physician. I will be responsible and discreet using the medication as described on the reverse side and should have this medication readily accessible. I have been instruction how to self-administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container. I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer this medication.

_____ _____
Student's Signature Date