Tuckerton Elementary School District

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Parent/Guardian Permission

Student Name_________________________________ D.O.B:_____/_____/_____

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Physician's Name   Physician's Phone Number

We/I request that my child be assisted by the school nurse in taking medication(s) as prescribed by my child's physician. We/I will indemnify and hold harmless the district and any and all employees of the district against any injury or claims that arise as a result of the nurse's administration of my child's medication. We/I realize that We/I must renew this certificate annually. We/I also give the school nurse permission to contact the physician below with regards to matters concerning our/my child's medication or condition. We/I understand that the school district and its employees and agents shall incur no liability as a result of any injury arising from the administration of medications, including epi-pen, of our/my child. We/I further understand that we/I hereby indemnify and hold harmless the school district and its employees and agents against any injury or claims arising out of the nurse's administration of our/my child's medications, including the administration of epi-pen by the school nurse or the individual designated by the school nurse who shall be permitted to administer epi-pen to our/my child when the nurse is not physically present at the scene.

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Date   Parent/Guardian's Signature   Home Phone #   Work/Emergency #

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Date   Parent/Guardian's Signature   Home Phone #   Work/Emergency #

PO Box 217, Marine Street, Tuckerton, NJ 08087 - Fax # 609-296-1480