

NORTH HALEDON SCHOOL DISTRICT

Memorial Elementary School
201 Squaw Brook Road
North Haledon, NJ 07508
Tel: (973) 427-8993
FAX: (973) 423-1514

High Mountain School
515 High Mountain Road
North Haledon, NJ 07508
Tel: (973) 427-1220
FAX: (973) 427-7685

**PARENT AUTHORIZATION AND RELEASE FORM
FOR STUDENT SELF-ADMINISTRATION OF MEDICATION**

Authorizations are effective for one school year only and must be renewed annually.

(Please print all information)

Child's Name _____
 Last **First** **Middle**

School _____ **Grade** _____ **D.O.B.** _____

Pursuant to N.J.S.A. 18A:40-12.3, the North Haledon Board of Education will permit the self-administration of medication by a student for asthma or other potentially life-threatening illnesses or allergic reaction under certain circumstances.

I, the parent/guardian of _____ hereby authorize the Board to allow my child to self-administer medication as instructed by my child's physician because my child has a potentially life-threatening illness or allergic reaction.

Along with this authorization, I am providing the Board with a written authorization and certification from my child's physician stating that my child has a potentially life-threatening illness or allergic reaction and is capable of and has been instructed in the proper method of self-administration of medication.

The Board has informed me, and I acknowledge, that the Board shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the Board and its employees or agents against any claims arising out of the self-administration of medication by my child.

The Board has informed me, and I acknowledge, that my permission is only effective for the _____ school year and must be renewed for each subsequent school year upon fulfillment of the requirements of the law.

Parent/Guardian Signature

Date