

The administration of medication by any student who has asthma or another potentially life-threatening illness will be permitted only when failure to take such medication would jeopardize the health of the student or the student would not be able to attend school if the medicine were not made available.

**PARENT CERTIFICATION**

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Physician: \_\_\_\_\_

I understand that my child is to carry his/her own medication and that he/she must secure this medication in such a manner that the medication will not be available to other students.

I acknowledge that the Monroe Township School District, the Board, and its employees or agents, shall incur no liability as a result of any injury arising from the self-administration of medication by my child; and I indemnify and hold harmless the school district, the Board, and its employees or agents from any claims arising out of the self-administration of medication by my child.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Approved: \_\_\_\_\_ Disapproved: \_\_\_\_\_

**The Administration of Medication Policy #5330 was Approved by the Board of Education on January 18, 2006.**