WINFIELD TOWNSHIP SCHOOL
7 ½ GULFSTREAM AVENUE
WINFIELD, NJ 07036
908-486-7410

HEALTH SERVICE
PARENT CONSENT FORM

I authorize that_____GR/HR_____, a pupil in the Winfield Public Schools, is capable of and has been instructed to carry and self-administer medication without medical supervision of the school nurse. This medication may be required from time to time for the treatment of_____, a potentially life threatening illness.

_____ , has been instructed and made fully aware of the following:
Student's name

1. Instructions in proper method for self-administration.
2. The medication is for his/her use only.
3. After self-administering medication in school or at school activities, the student must report to the school nurse, coach, or teacher immediately.

Additionally, I accept full responsibility for any reaction or condition which may occur due to the above. Furthermore, I exonerate the Winfield Board of Education, their employees and agents, from any claims arising out of self-administration of medication by the pupil associated with the above.

Name of Medication_____

Frequency_____ Dosage_____

Duration_____

Possible Side-effect (list or attach info):_____

_____

_____

Parent/Guardian Signature_____ Date_____

Primary Physician's Signature_____Date_____

Address_____

School Physician's Signature_____Date_____

Principals's Signature_____Date_____

Ri/Nurse/Parent consent form for medication