Marie H. Katzenbach School For The Deaf
Student Health Center
P.O. Box 535
Trenton, NJ 08625-0535
Voice 609-530-3167 / TTY - 609-530-3169 / Fax - 609-530-3168

Student Self-Administration of Asthma Medication

TO BE COMPLETED BY PARENT/GUARDIAN

I/We hereby authorize Katzenbach School to allow my/our child ___________________________________
to carry the following asthma medication ____
and self administer it, as necessary, according to his/her doctor's instructions.

I/We also acknowledge that the school and its employees shall incur no liability as a result of any injury arising from the self administration of the above medication by the student.

This agreement will remain in effect for the school year___________________ only and must be renewed annually.

____ ___________________
Parent/guardian signature Date

TO BE COMPLETED BY THE PHYSICIAN

I certify the above named student is capable of and has been instructed in the proper method of self administration of the following medication:

NAME OF MEDICATION:____

DIRECTIONS: ____

SIDE EFFECTS:____

Physician's signature:____ Date:______________________

Telephone:____