MONTGOMERY TOWNSHIP SCHOOLS
Skillman, New Jersey
School Health Services

SELF-ADMINISTERING REQUEST FROM PARENT

I hereby request that my child self-administer the following medication.

Name____

Teacher/Grade____

Name of Medication____

Dosage____

Reason for Medication____

Signature of M.D.________________________________ Phone______________________

Parents Signature____

Date____

Must Be Renewed Every Year

MAY ONLY SELF MEDICATE
EPIPENS FOR LIFE THREATENING ALLERGIES
INHALERS FOR ASTHMA