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**