HIGH POINT REGIONAL HIGH SCHOOL
Health Office
Physician's Certification for Student To Self-Administer Medication
For school year 2016-17

Student's Name: ____

Grade: ____________________ Date of Birth: ______________________

Diagnosis/reason medication is prescribed: ___________________________

Name of Medication(s): ______________________________________

Dosage: ____

Method of Administration: _____________________________________

When medication should be taken: ______________________________

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I certify that the above named student is capable of and has been instructed in the proper administration of the specified medication. Please allow this student to carry and self-administer the medication at school.

Physician's Signature: __________________________ Date: ____________

Physician's Printed Name: ______________________________

Address: ______________________________

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Telephone # ______________________________

** *Please note: This form is for "potentially life-threatening illnesses" only, such as bee sting allergy, asthma, diabetes, and cystic fibrosis. No other medications are permitted to be carried and self administered by students.*

Reviewed by: Principal ___________________________________

School Physician ___________________________________

School Nurse ___________________________________