

HIGH POINT REGIONAL HIGH SCHOOL

Health Office

**Physician's Certification for Student
To Self-Administer Medication
For school year 2011-2012**



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: _____

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: _____

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 _____