Our Lady Help of Christians Academy

Physician's Statement
Medication Self-Administered by Student at OLHCA
Academic Year 2024-2025

Date:

Name of Student: Birthdate:

The above-named student may require self-administered medication during school hours.

Condition for which medication may be needed:

Name of medication:

Purpose of medication

Time medication should be administered:

Special circumstances requiring administration of medication:

_____

Length of time medication should be taken: _____

Signed _____

_____ _____
Printed name of physician *Degree*

_____
Address of medical practice

_____
City, State, ZIP

THE DOCUMENTATION OF STUDENT'S ABILITY TO ADMINISTER THIS MEDICATION MUST BE COMPLETED (See reverse side of form)

Form Revised 6/2016

Name of Student: Date of birth:

Student *must* demonstrate proficiency in the self-administration of this medication, either to the physician or to appropriate school personnel

This student has demonstrated to me his/her proficiency in the self-administration of this medication.

Signed:

Printed Name:

Please check one: I am a

☐ Physician ☐ Nurse ☐ Other Health care provider (describe below)

_____

☐ School Nurse ☐ School personnel designated to observe this proficiency

☐ Other (describe below)

_____