

# *Our Lady Help of Christians Academy*

## **Physician's Statement Medication Self-Administered by Student at School Academic Year 2020-2021**

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: \_

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Length of time medication should be taken: \_\_\_\_\_

Signed \_\_\_\_\_

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*Printed name of physician* \_\_\_\_\_ *Degree* \_\_\_\_\_

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*Address of medical practice* \_\_\_\_\_

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*City, State, ZIP* \_\_\_\_\_

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

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)

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School Nurse  School personnel designated to observe this proficiency

Other (describe below)

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