

School Year: September\_\_\_\_\_ - June\_\_\_\_\_

I hereby certify that \_\_\_\_\_, has

(student name)

\_\_\_\_\_ and that he/she is capable of, and has  
(life-threatening illness ie., asthma) been instructed in, the proper method  
of self-medication.

Name of  
Medication:\_\_\_\_\_

Purpose of  
Medication:\_\_\_\_\_

Time, Dosage and Route of  
Medication:\_\_\_\_\_

Possible Side  
Effects:\_\_\_\_\_

Medication Discontinue  
Date:\_\_\_\_\_

Special Instructions or  
Comments:\_\_\_\_\_

\_\_\_\_\_

This medication must be administered during the school day or the pupil will  
not be able to attend school:

Yes\_\_\_\_\_ No\_\_\_\_\_

This student is physically fit to attend school and is free of contagious  
disease and would not be able to attend school if medication was not  
available for administration during school hours.

Doctor's Signature:\_\_\_\_\_ Date:\_\_\_\_\_

Print Name:\_\_\_\_\_ Phone #:\_\_\_\_\_

**The Administration of Medication Policy #5330 was Approved by the Board of Education on January 18, 2006**