STERLING HIGH SCHOOL

HOME OF THE SILVER KNIGHTS

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PHYSICIAN'S CERTIFICATION FOR SELF-ADMINISTRATION OF MEDICATION BY STUDENT
for Students with Asthma or Other Potentially Life-Threatening Illness

STUDENT NAME: _____ D/O/B: _____

NATURE OF ILLNESS/CONDITION: _____

TYPE OF MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

POSSIBLE SIDE EFFECTS: _____

The minor individual named above is my patient. I understand that this patient is a student in your school district. I further understand that Chapter 308 of the Laws of 1993 allows the parents or guardians of a student who as asthma or other potentially life-threatening illness to authorize self-administration of medication by the student so long as the student's physician certifies to the school district that the student is capable of, and has been instructed in, the proper method of self-administration of medication.

My patient suffers from the illness or condition identified above and is required to take the medication also identified above. My patient is capable of, and has been instructed in, the proper method of self-administration of this medication. In the event the medication which I have prescribed is changed in the future, I will either assure that my patient remains capable of, and has been instructed in, the proper method of self-administration of said medication or I will notify the school district that my patient is no longer capable of, or has not been instructed in, the proper method of such self-administration.

I understand that the authorization by my patient's parents or guardians is effective only for the current school year and must be reauthorized by them for each future school year. Any such reauthorization by my patient's parents or guardians for any future school year must be accompanied by a new certification by me.

_____ _____
SIGNATURE OF PHYSICIAN DATE

_____ _____
PRINT NAME OF PHYSICIAN PHONE NUMBER

_____
PHYSICIAN'S OFFICE ADDRESS