HIGH POINT REGIONAL HIGH SCHOOL
Health Office
Physician's Certification for Student
To Self Administer Emergency Medication

Student's Name:_____School Year_____

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/sporting events.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Address:_____

Telephone # _____

** *Please note: This form is for "potentially life threatening illnesses" only, such as anaphylaxis, asthma, diabetes, and cystic fibrosis. No other medications are permitted to be carried and self administered by students.*