

MILLVILLE PUBLIC SCHOOLS
MILLVILLE, NEW JERSEY

Appendix B

PHYSICIAN'S STATEMENT
SELF-ADMINISTRATION OF MEDICATION

Student's name _____

DOB _____

is currently under my care for _____.

In order to prevent a potentially life threatening illness it is necessary that the following medication be administered:

Name of medication: _____

Purpose of medication: _____

Dosage and route: _____

Time of administration: _____

Self-medication criteria:

Student is :

- | | | |
|--|------------------------------|-----------------------------|
| A. capable of identifying individual medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. knowledgeable of purpose of individual medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. able to identify /associate specific symptom occurrence and need for medication administration? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. capable/knowledgeable of medication dosage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. knowledgeable about method of medication administration? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. able to state side effects/adverse reactions to the medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. knowledgeable and has demonstrated ability to self-medicate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H. capable of self-medicating? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I. knowledgeable of how to access assistance for self if needed in an emergency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| J. authorized to self-medicate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: _____

I certify that the above information regarding this student is correct, and that administration of the medication to this student is necessary.

Physician's name

Physician's signature

Address

Phone

Date