Monmouth County Vocational School District

PHYSICIAN CERTIFICATION FOR SELF-MEDICATION BY A STUDENT WITH A LIFE-THREATENING ILLNESS/ALLERGIC REACTION

In accordance with P.L. 2007, c.57, _____ (print name of physician) certify that I am the physician of _____ (print name of student). This patient suffers from _____ (print name of illness), a potentially life-threatening illness/allergic reaction, and is capable of, and has been instructed in, the proper method of self-administration of medication for this illness/allergic reaction.

_____(print name of student) is physically fit to attend school and is free of contagious disease **and** would not be able to attend school if the medication is not administered during school hours.

Name of Medication: _____

Dose and Route: _____

Time: _____

Side Effects: _____

Period of time to be administered:_____

Additional Instructions: _____

_____

_____	_____	_____
Signature of Physician/Stamp	Telephone	Date

Reviewed and approved by:

_____	_____
Signature of School Physician	Date

Revised 12/22/15