FREEHOLD TOWNSHIP SCHOOLS

PHYSICIAN'S REQUEST FOR STUDENT WITH LIFE THREATENING CONDITION TO SELF ADMINISTER MEDICATION

1. I hereby certify that _____ has

_____ (state diagnosis) which requires

medication with the following:

NAME OF MEDICATION_____

PURPOSE OF ITS ADMINISTRATION_____

DOSAGE_____ METHOD OF ADMINISTRATION_____

FREQUENCY OF USE_____ SIDE EFFECTS_____

_____

LENGTH OF TIME THE ORDER IS VALID (may not exceed school year) _____

2. I certify that this child is capable of, and has been instructed in, the proper method of self administration of this medication. I recognize that this order is valid for the school year and must be personally signed by me (**stamps and counter signatures will not be accepted**).

_____ _____

DATE PHYSICIAN'S **SIGNATURE**

_____

NAME OF PHYSICIAN/STAMP