Physician Certification to Authorize Student Self-Administration of Emergency Treatment at School

Certificación para la Autorización de Auto-Administración de Tratamiento de Urgencia Estudiantil

Student Name:_____Date of Birth:_____

Student Disease or Medical Condition: _____

Medical Supplies Needed for Emergency Treatment:_____

_____

_____

Lake Station Community Schools will allow the student to carry and self-administer emergency treatment and/or medication if you provide the following certification.

I certify that:

1. I am a physician licensed to practice medicine or osteopathic medicine in the state of: _____.
2. The above student has an acute or chronic disease or medical condition for which I have prescribed medication/treatment.
3. I have instructed the student on how to self-administer this medication/treatment. This student can safely and properly self-administer the above medication/treatment in the school setting.
4. The nature of the disease or medical condition requires emergency administration of this medication/treatment.

_____

Student's Physician/Health Care Provider Date

_____

Parent/Guardian Date

*__NOTE- It is the recommendation of Lake Station Community Schools that the student inform a school employee, especially the school nurse, whenever self-administration of the above medication or treatment has occurred.__