ADMINISTRATION OF MEDICATIONS TO STUDENTS
(Physician Certification)

I certify that I am a licensed physician authorized by law to prescribe medication.

I have prescribed or ordered _____ ("Medication") for_____
("Student") to treat/manage _____ ("Condition").

I further certify that:

- ❑ I have instructed Student in the correct and responsible use of Medication.
- ❑ I have attached a treatment plan for managing Student's Condition.
- ❑ Student is capable of self-administering Medication in accordance with the treatment plan and has demonstrated to me or my designee the skill level necessary to self-administer Medication.

_____
Printed Name of Physician

_____
Signature of Physician

_____
Date

* * * * * * *

Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.

Implemented: 01/22/2007

Clinton School District #124, Clinton, Missouri