



SAINT MARY'S ACADEMY

TRADITIONAL CATHOLIC SCHOOLS OF THE SOCIETY OF ST. PIUS X
200 EAST MISSION STREET SAINT MARYS, KANSAS 66536
PHONE 785-437-2471 • FAX 785-437-6597

Student Self-Administration of Medication at School, 2017-2018

Physician's Statement

Name of Student: _____ Birthdate: _____

The above-named student may require self-administered medication during school hours.

Condition for which medication may be needed: _____

Name of medication: _____

Purpose of medication: _____

Time medication should be administered: _____

Special circumstances requiring administration of medication: _____

Length of time medication will be required: _____

Physician's signature

Date

Physician's name (please print)

Degree

Address of medical practice

City

State

Zip

**THE DOCUMENTATION OF STUDENT'S ABILITY TO ADMINISTER THIS
MEDICATION MUST BE COMPLETED (See reverse side of form)**

Documentation of Student Proficiency in Self-Administering Medication

Name of Student: _____ Birthdate: _____

Name of medication: _____

Student *must* demonstrate proficiency in the self-administration of this medication, either to the physician or to appropriate school personnel

This student has demonstrated to me his/her proficiency
in the self-administration of this medication.

Signed: _____ Date: _____

Printed Name: _____

- I am a (please check one):
- Physician
 - Nurse
 - Other Health-care provider (describe below)
 - School Nurse
 - School personnel designated to observe this proficiency
 - Other (describe below)
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