SAINT MARY'S ACADEMY
TRADITIONAL CATHOLIC SCHOOLS OF THE SOCIETY OF ST. PIUS X
200 EAST MISSION STREET SAINT MARYS, KANSAS 66536
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Student Self-Administration of Medication at School, 2018-2019

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)

Form Revised 4/11/2018

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)

_____

Form Revised 4/11/2018