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: December 20, 2006

Revised:

Boonville R-I School District, Boonville, Missouri