*Hamilton Southeastern Schools*

**PHYSICIAN CERTIFICATION TO AUTHORIZE STUDENT SELF-ADMINISTRATION OF EMERGENCY MEDICATION AT SCHOOL**

Student Name: _____

Student Disease or Medical Condition: _____

Name, Dose and Route of Medication(s): _____

_____

_____

Hamilton Southeastern Schools will allow the student to carry and self-administer emergency medication if you, as their physician, 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.

3. I have instructed the student on how to self-administer this medication.

4. The nature of the disease or medical condition requires emergency administration of this medication.

Physician Signature: _____ Date: _____

* NOTE – It is the recommendation of Hamilton Southeastern Schools that the student inform a school employee, especially the school nurse, whenever self-administration of the above medication has occurred.