MONTGOMERY TOWNSHIP SCHOOLS
Skillman, New Jersey

SCHOOL HEALTH SERVICES

Re: PHYSICIANS CERTIFICATION FOR SELF-ADMINISTERING MEDICATION

Dear_____
School Nurse

I hereby request that my child self-administer the medication listed below:

Name of Child_____

School/Grade_____

Name of medication_____

Dosage_____

Life Threatening Condition_____

Name of M.D.(print)_____

Signature of M.D._____

Phone number of M.D._____

*Duration of administration_____

Signature of Principal_____

_____

Date **Signature of Parent or Guardian**

***Must be renewed each year.**