CHARTER HIGH SCHOOL FOR
ARCHITECTURE + DESIGN
105 SOUTH 7TH STREET
PHILADELPHIA PA 19106

Authorization for Self-Administration of Medication by Student

To: Susan Cook, School Nurse

Re: _____
Patient's Name

Year: _____

The minor individual named above is my patient. I understand that this patient is a student in your school.

I further understand that the parent(s)/guardian(s) of a student who has asthma or other potentially life-threatening illnesses may authorize self-administration of medication by the student so long as the student's physician certifies that the student is capable of, and has been instructed in, the proper method of self-administration of medication.

My patient has an illness or condition identified at the end of this form and is required to take the mediation also identified at the end of this form.

My patient is capable of, and has been instructed in, the proper method of self-administration of this medication. In the event that the medication which I have prescribed is changed in the future, I will either assure that my patient remains capable of, and has been instructed in the proper method of self-administration of said medication, or will notifiy the school that my patient is no longer capable of, or has not been instructed in, the proper method of self-administration.

I understand that the authorization by my patient's parent(s) or guardian(s) is effective only for the current school year and must be re-authorized by them for each future school year. Any such reauthoriation by my patient's parent(s) or guardian(s) for any future school year must be accompanied by a new certification by me.

Dated:

Nature of Illness or Condition:

Type of Medication:

Directions:

_____
Signature of Physician

_____
Signature of Parent