

**Monmouth County Vocational School District**

**PHYSICIAN CERTIFICATION FOR SELF-MEDICATION BY A STUDENT WITH A LIFE-THREATENING ILLNESS/ALLERGIC REACTION**

In accordance with P.L. 2007, c.57, \_\_\_\_\_ (print name of physician) certify that I am the physician of \_\_\_\_\_ (print name of student). This patient suffers from \_\_\_\_\_ (print name of illness), a potentially life-threatening illness/allergic reaction, and is capable of, and has been instructed in, the proper method of self-administration of medication for this illness/allergic reaction.

Name of Medication: \_\_\_\_\_

Dose and Route: \_\_\_\_\_

Time: \_\_\_\_\_

Additional Instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Side Effects: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician/Stamp

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

Reviewed and approved by:

\_\_\_\_\_  
Signature of School Physician

\_\_\_\_\_  
Date