JACKSON SCHOOL DISTRICT

151 Don Connor Blvd
Jackson, NJ 08527

(732) 833-4600

Student: _____ Grade: _____ Date: _____

Certification of Physician

1. I am a licensed physician with offices located at _____

   _____

2. I hereby certify that I have treated _____ for _____ which is a potentially life-threatening illness.

3. I also certify that _____ is capable of, and has been instructed in, the proper method of self-administration of medication for his/her illness.

4. Name of medication _____

5. Dosage _____

6. Frequency of administration _____

7. Side effects _____

8. Certified School Nurse name _____

Please Sign and Stamp with Office Stamp

_____ _____
Physician's Signature Date

9. **As this student's physician, I deem them unable to self-administer their life saving Epipen. I recommend the Certified School Nurse or designate administer the Epipen at the first contact with allergen.**

_____ _____
Physician Signature Date

Rev 7/04