Robert Bassett
Principal

Jack L. Boyd Outdoor School
Consent for Self-Administration of Medicine

Steven E. Gomes, Ed.D.
Superintendent

TO BE COMPLETED BY PHYSICIAN

(Self-Administration form **side 2 of 2**, copy as needed for additional medications)

Physician's Statement Supporting Student's Self-Administration of Medication

1. Pursuant to Education Code Sections 49423 and/or 49423.1, this is to confirm that ____________________________(student) DOB: __________________ is able to self-administer the following medication(s):

   ☐ Auto-injectable epinephrine ☐ Inhaled asthma medication

2. The name of the medication is: ____
3. The condition for which the medication is to be given is: ____________________
   ____
4. The method of self-administration is: ________________________________
5. The amount of medication to be taken per administration is: ______________
6. The time schedule of administration of medication is: ____________________
7. Other instructions: ____
   ____
   ____

I certify that the foregoing is true and correct.

______________________________________ Date: ______________________
Signature of Physician

______________________________________ Phone Number: _______________
Printed Name of Physician

______________________________________ Fax Number: _________________
Address