Written Certification from Licensed Healthcare Provider for Self-Administration of Medication for Students with Diabetes

1. The undersigned is the healthcare provider of _____.
   (Name of Child)

2. The undersigned is a _____physician, _____Physician Assistant, or _____ Advance Practice Registered Nurse, who provides medical treatment to the above named child.

3. The patient, _____, is being treated by me for diabetes.
   (Name of Child)

   a. With regard to such treatment, the following medication has been prescribed:

   _____
   (Name of Medication)

   b. The prescribed dosage of such medication is as follows:

   _____

   c. The time or times at which the medication shall be taken is:

   _____

   d. Special circumstances, if any, under which the medication is also to be administered is as follows:

   _____

   _____

4. My patient _____ is able to self-administer the above referenced medication in the prescribed dosage and the prescribed times as outlined above.

_____ _____
(Signature of Healthcare Professional) (Printed Name of Healthcare Professional)

_____
Address: City State Zip

_____ _____
Phone Number Date