Schertz-Cibolo-Universal City Independent School District
Health Services
1060 Elbel Road, Schertz, Texas 78154

SELF-ADMINISTRATION MEDICATION FORM

(For Asthma, Diabetes, Seizures and Severe Allergies requiring an Epi-Pen)

Physician Form

Student Name___________________________Teacher/Grade Level_________________

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis____

Name of medication	Dose	Time/Frequency	Duration
1) ___________________________	_________	_____________	____________
2) ___________________________	_________	_____________	____________

Please explain any restriction and /or emergency measures to be followed:____________

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In signing this form I am certifying that in my professional opinion, this student has adequate knowledge of their health condition and above stated medications. I am aware that school personnel are available at all times to administer medication. I have discussed with the student and parent the risk/dangers of overmedication and in my opinion, the student and parent have adequate understanding of the condition to safely and responsibly self-administer the above medications as prescribed.

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Physician Signature

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Printed Physician Name/Office Number

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Today's Date