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.

Dosage

_____

8. Certified School Nurse name _____